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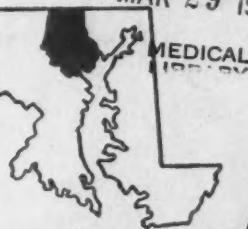
Official Publication of the

**MEDICAL AND CHIRURGICAL FACULTY  
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MAR 29 1955

BALTIMORE COUNTY ISSUE



# Maryland

STATE MEDICAL JOURNAL

L. 4 NO. 3

March, 1955

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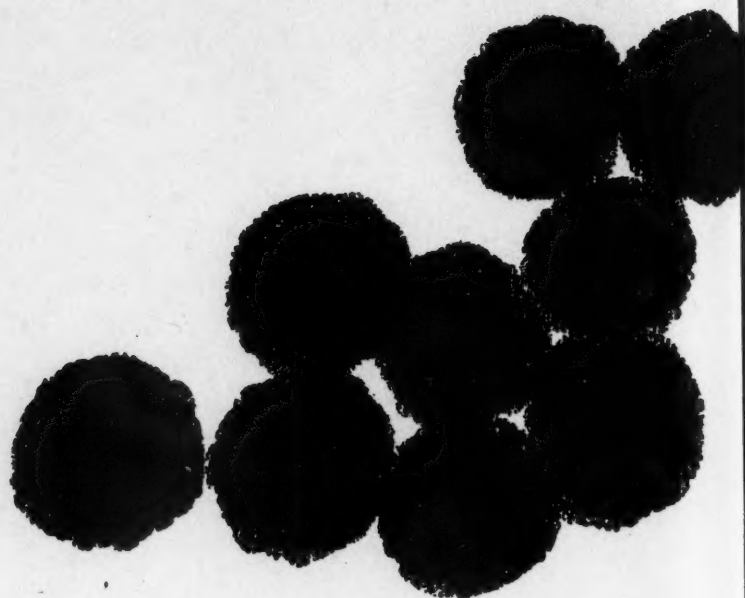
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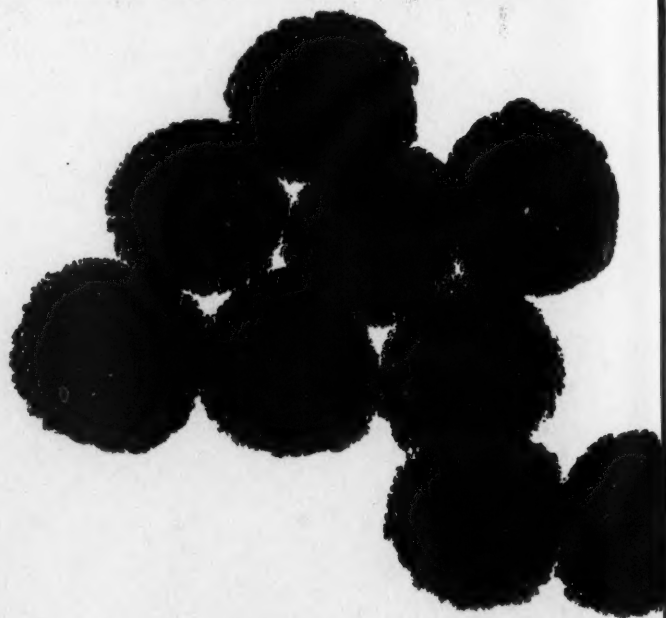
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ANNUAL MEETING—THURSDAY, FRIDAY, SATURDAY, APRIL 21, 22, 23, 1955



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# MARYLAND

## STATE MEDICAL JOURNAL

*Medical and Chirurgical Faculty of the State of Maryland*

1211 CATHEDRAL STREET, BALTIMORE 1, MARYLAND

Official Publication of the Medical and Chirurgical Faculty of the State of Maryland

VOLUME 4

March, 1955

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\* Second Baltimore County Medical Association Issue.

# THE MARYLAND STATE MEDICAL JOURNAL

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# Maryland STATE MEDICAL JOURNAL

*Medical and Chirurgical Faculty of the State of Maryland*

VOLUME 4

March, 1955

NUMBER 3

## ANNUAL MEETING, APRIL 21, 22, AND 23, 1955

Note it now! Plan your schedule to participate in the Annual Meeting functions that have been arranged by the Committee on Scientific Work and Arrangements.

### THURSDAY, APRIL 21, 1955

The morning will be set aside for the meeting of the House of Delegates at the Deutsches Haus, 1212 Cathedral Street, to which all members of the Faculty are most welcome. When you attend these meetings you will be conversant with the activities of the officers and committees of your Association and will understand the work that is being accomplished for the people in Maryland through your Medical Association. The Council meeting, which will precede the House of Delegates, will be held in the Friedenwald Room of the Faculty Building.

### LUNCHEON

Sheraton Belvedere Hotel

This is under the auspices of the Woman's Auxiliary to the Medical and Chirurgical Faculty, and the members and their wives are welcome.

### AFTERNOON SCIENTIFIC SESSION

Osler Hall, 1211 Cathedral Street

Infection in the Newborn. E. R. McCluskey, M.D., Pittsburgh, Pennsylvania.

Discussion on Hearing and Speech.

The General Practitioner As An Urologist. Elmer Hess, M.D., Erie, Pennsylvania.

### EVENING MEETING

Ballroom, Sheraton Belvedere Hotel

Presidential Dinner, 6:30 P.M.

(Dress Optional)

Presidential Address. George H. Yeager, M.D., Baltimore, Maryland.

I. Ridgeway Trimble Lecture. "Are We Afraid to Face Facts." Elmer Hess, M.D., Erie, Pennsylvania, President-elect, American Medical Association.

*(Continued on next page)*

**FRIDAY, APRIL 22, 1955**

There will be a business session of the House of Delegates at the Deutsches Haus, 1212 Cathedral Street.

**MORNING SCIENTIFIC SESSION**

Osler Hall, 1211 Cathedral Street

New Ideas in the Diagnosis and Control of Hypertension. Caroline Bedell Thomas, M.D., Baltimore, Maryland.

Election of Board of Medical Examiners.

New Concepts in the Pathogenesis and Treatment of Coronary Artery Disease. Sidney Scherlis, M.D., Baltimore, Maryland.

Ophthalmoscopic Diagnosis in Vascular Disease. Alan C. Woods, M.D., Baltimore, Maryland.

**AFTERNOON SCIENTIFIC SESSION**

Osler Hall, 1211 Cathedral Street

John M. T. Finney Fund Lecture. Advancement of Surgical Treatment of Peptic Ulcer. Deryl Hart, M.D., Durham, North Carolina.

Automotive Crash Injury Research. Mr. John O. Moore, New York City.

Subject to be announced. Anthony F. DePalma, M.D., Philadelphia, Pennsylvania.

**FRIDAY EVENING**

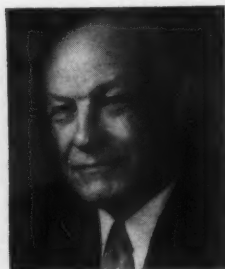
THE BALL, Emerson Hotel, 9:30 P.M.

**SATURDAY, APRIL 23, 1955**

Last session of this meeting of the House of Delegates, Deutsches Haus, 1212 Cathedral Street.

**MORNING SCIENTIFIC SESSION**

The program for the Clinical Pathological Conferences will be arranged by the Johns Hopkins University School of Medicine and the University of Maryland School of Medicine.



ELMER HESS, M.D.



DERYL HART, M.D.



ANTHONY F. DePALMA, M.D.



MR. JOHN O. MOORE



### EDITORIAL

## THE BALTIMORE COUNTY MEDICAL ASSOCIATION ACTS†

It is with a sense of satisfaction, achievement and, let it be thought, with pardonable pride that the Baltimore County Medical Association welcomes this the second BALTIMORE COUNTY ISSUE OF THE MARYLAND STATE MEDICAL JOURNAL. The enthusiastic response of the many contributors in Baltimore County for original manuscripts and articles has been truly tremendous and pleasantly surprising to our membership and, we hope, to the Editor of the MARYLAND STATE MEDICAL JOURNAL. And yet this outpouring of interest and diligence on the part of those who have contributed is neither astonishing nor entirely unexpected if we pause to reflect upon the kind and character of the Association we have developed in Baltimore County.

All of us subscribe wholeheartedly to the fact that we have presently an active, energetic and wide-awake medical association in Baltimore County. It was not always so; and this very circumstance turned out to be both a challenging and a stimulating factor in our rebirth and rededication of services to our membership and to the people of Baltimore County. It was some seven years ago that we took stock of ourselves and found that an unbiased observer could candidly describe our Association as neither above nor below the average medical association in Maryland. Actually, after the usual meeting with a short scientific session, the membership promptly hibernated until the next regular assemblage the following month. Perhaps it was seeing ourselves in a mirror and comparing our visage with the look of some successfully rejuvenated medical societies in the country as a whole which gave us the essential force to change for the better. In any event, ideas were conceived and expressed, plans were developed and, through teamwork among ourselves and others in the community, things began to happen.

One of the first steps toward the goal of strengthening our Association was the sending of a carefully edited letter to the entire membership and thereby seeking the answers to some searching and basic questions: On what day of the month and at what time of the day should meetings be held? What kind of scientific presentation would be provocative and practical? What are some frank suggestions for the possible restatement of objectives and for the improvement of the organization of the Association? From a

\* First Baltimore County issue November, 1954. This Edition represents the completion of sponsored issues by the Baltimore County Medical Association.

† Editorial written by the following: *Board of Governors:* Martin E. Strobel, M.D., *Chairman;* Thomas E. Wheeler, M.D.; Louis Z. Dalmau, M.D.; Clarence E. McWilliams, M.D.; Melvin B. Davis, M.D.; George S. M. Kieffer, M.D.; Charles F. O'Donnell, M.D.; William H. F. Warthen, M.D.

careful review and a minute consideration of the answers came the change to a definite day and time each month for a meeting held in different locations in or near the County. This plan of action readily permitted at least three meetings each year to take place within five miles of any member's area of practice, except for those few living on the remote fringes of the County.

Next came the hard work of some indefatigable members in compiling and publishing the *Directory of the Baltimore County Medical Association*. This valuable publication for the people of Baltimore County catalogues the names and addresses and kinds of practice of all physicians of the Association, and the areas in the County in which they are located. There are listed all the pharmacies by County areas. Concise information is given about Blue Cross and Blue Shield and the Emergency Medical Care Plan for the County. The latter includes the telephone number and description of the twenty-four hour service provided by the emergency medical service of the County in association with the City of Baltimore. In Pikesville, Randallstown, Rockdale, Reisterstown and vicinities such a service is provided on a rotating basis for week ends and holidays. Copies of the Directory are placed in every station of the Police Department and Fire Department, in public schools, in libraries, in health centers, in the offices of real estate brokers and in all pharmacies. The Welcome Wagon, an organization personally welcoming new residents to the County, places a Directory in each of its gift packages. More than 20,000 copies of this timely and helpful booklet were distributed from these and many other locations throughout the County in 1954.

There followed then a third and far-reaching event. This was the integration of the Baltimore County Medical Association with the Health Department's advisory groups in The Baltimore County Health Council. Through free discussions of public health plans and activities in both the Baltimore County Committee on Medical Care and the Baltimore County School Health Council, the Health Department can and does have the support of the Medical Association. The School Health Council has been a motivating force in the enviably good cooperation of the public and private schools with the Association. Through the Health Council as a whole we are indebted to our Director of Health for his able and productive efforts, and those of his staff, to execute a highly cooperative health program.

Almost at the same time there began a continuingly close and fine relationship between the Baltimore County Public Health Association, the voluntary health agency in the County, and the Baltimore County Medical Association. We are grateful here for the understanding and cooperation of the President of the Baltimore County Public Health Association and the members of the Executive Committee of that Association. The truly joint efforts of the many neighborhood Health Centers sponsored by the Baltimore County Public Health Association, and the physicians of the County with regard to the detection of tuberculosis and follow-up of contacts and patients have, we believe, a bearing upon the favorably declining mortality from this disease in the County.

After all this had been accomplished, various forms of public relations were inaugurated to advise our patients of the activities and provisions of the Baltimore County Medical Association and to invite their acceptance or criticism. We in turn informed them of the purposes the Medical Ethics Committee and the Grievance Committee have for adjudicating any misunderstandings of a medical practice nature that might arise in the community. It became a natural sequence for the Association to endorse and to appoint a board from its membership to advise upon the activities of a professional billing corporation which was prepared to handle the accounts of any members

who desire such service. It should be emphasized that this corporation is a billing and not a collection agency for delinquent accounts. Notation by the subscribing physician of services rendered is used by the agency for billing all patients promptly. When handled in this ethical and professional way, the need for a bill-collecting company, which always seems to antagonize the patient to a greater or lesser extent, is eliminated. It can be reported that as a result of this particular system of billing, now widely used by many members of the Baltimore County Medical Association, most physicians' accounts are averaging more than 95 per cent payment within ninety days.

There is much left to be done in our county and, if we may be so bold to aver, in every other county in order to "clean our house" before the Government would do it for us. But we in Baltimore County feel we have at least taken the first steps. In this great endeavor and with the valued help and advice of the Medical and Chirurgical Faculty of Maryland and with the unexcelled opportunity for publication given us so generously by the Editor and Staff of the *MARYLAND STATE MEDICAL JOURNAL*, we hope to reach even greater achievements, and in the not too far distant future.

## THE PROBLEM BEFORE US IN TUBERCULOSIS

WILLIAM NEWCOMER, M.D.<sup>1</sup> AND ELMER P. SAUER, M.D.<sup>2</sup>

We are now living in a time of gratifying improvement in the treatment of tuberculosis. The problem has been to retain what has proven useful in the past and to add what is practical in the present. This means change and constant reevaluation. Some of the advances have taken place because of research but many of the present discoveries in treatment have been on a more or less accidental pattern. A look at what is ahead in the immediate future would appear to be appropriate at this time.

To us it is important that we keep the ultimate goal of eradication of this disease in mind. It appears at the present time that this goal will only be achieved far in the future but the ideal is worthy of our constant attention. Prevention is always superior to treatment; however, it is most necessary that we have adequate treatment in order to achieve eradication. The prevention of infection today will mean fewer cases

in the future. Tuberculosis is the type of disease where an infected person may suffer a clinical activation of his lesion many years later. In 1900, in our large cities, many died of tuberculosis but today, there has been a tenfold decrease in mortality. A number of factors contributed to this decrease in mortality. The social aspects of this disease as reflected in food, rest, and housing are quite important. In some countries where the social aspects have not improved, the death rate still remains as high as previously.

Segregation of the tuberculous case in the hospital, and thereby separation from the community, has decreased the number of people being infected. Improved treatment since 1947 has caused a marked decline in the mortality. We are sure that in the future this will be reflected in a declining morbidity. Today, the number of cases found remains about the same as in the past but some of the cases now found are due to more intensive case finding. Tuberculosis formerly was found more frequently in the young but is now found more in the older adult male. This trend is likely to continue into

<sup>1</sup> Superintendent, Mount Wilson State Hospital, Mount Wilson, Maryland.

<sup>2</sup> Medical Director, Maryland Tuberculosis Hospitals, Mount Wilson, Maryland.



the near future. This older adult person is the hardest to find by survey and is often reluctant to leave his job or position in society to seek adequate treatment. This positive sputum case is a very potent source of dissemination and will make the problem of eradication difficult, unless community opinion will rally for good control measures. Tuberculosis is still most prevalent among the poor and the crowded. Measures aimed in this direction are and will be important. The cases here must be detected, aided and sheltered, because one case of infectious disease in a community affects the entire community. It is hoped in the future that methods of detection will be found which will be better than x-ray survey.

At the present time there is some opinion that we are not curing tuberculosis but prolonging life. The authors are personally much more optimistic. It is true that in many cases life is prolonged but also in the adequately treated case with closed cavities we are achieving a good result and when the time comes for the person eventually to be a mortality statistic it will be from a non-tuberculous cause.

Today there has been marked improvement in the treatment of tuberculosis with the use of the anti-tuberculous drugs, Streptomycin, Para-Aminosalicylic Acid, Isonicotinic Acid Hydrazide, and Viomycin. While it is true, that of the many remedies tested, these four had been chosen, there is no reason to believe that these drugs will continue to be the best available. A great variety of new drugs are being tested at the present time and better ones eventually should be found. The present anti-tuberculous medications have certain failings. It is hoped to correct these by either alteration or modification of the drugs or by substitution of better formulas. Let us consider these medications individually and then in combination.

Streptomycin or Dihydro-Streptomycin must be given intra-muscularly to be effective. If given orally there is merely partial sterilization of the gastro-intestinal tract. In the hospital intra-

muscular medication is a problem but it is a much greater problem where patients are widely scattered throughout the community. A great deal of time is consumed outside the hospital in administering the drug by doctor or nurse. It frequently is quite difficult and very time-consuming for the patient to report to the doctor's office in rural areas. Many patients are quite adverse to an injection being given or even to the thought thereof. In those cases where patients are taught to use the medicine intra-muscularly at home, the doctor or nurse feels insecure concerning sterility of the injection. At times it has also been known that patients have not taken the medication although pretending that they had. When the medication is given intra-muscularly by the nurse at least one is sure that the patient has secured the desired medication. It is hoped in the future that the active principle of Streptomycin, Dihydro-Streptomycin, or a substitute can be given orally. Many reactions occur to Streptomycin or Dihydro-Streptomycin. Some of these reactions may be due to impurities in the drug that might be eliminated by further methods of purification or alteration in the medication form. A considerable amount of work is being done with the anti-histimines and other drugs in an attempt to relieve some of the allergic reactions. Desensitization methods have been used locally by a few people and are worthy of much further application. However, even with anti-histimines drugs and desensitization, the patient cannot always be relieved of troublesome toxic side effects and the drug must frequently be stopped.

Para-Aminosalicylic Acid, known as P.A.S., is a very difficult drug to use. It has the virtue of being given by mouth but must be used in very large doses. This drug with aging deteriorates with the formation of undesirable side products. We have encountered many reactions in the form of skin rashes, febrile reactions and nausea. This drug, above all others, needs replacements. Para-Aminosalicylic Acid is a rather weak drug and it should not be too difficult in

the future to find a substitute which is a relatively stable compound and which can be given without toxic side reactions.

At the present time Isonicotinic Acid Hydrazide, called INH, comes closest to being the ideal drug. It is relatively non-toxic, cheap and it can be given by mouth. The few side effects that are seen will probably be those referable to the nervous system. In chronic cases, especially when used alone, this drug has not been too effective. However, it is quite effective in acute cases. Drugs of this type with better therapeutic response would be ideal for future development.

Viomycin is therapeutically not as effective as Streptomycin. Its toxicity and drawbacks are similar to Streptomycin. It also may have an undesirable effect on the kidney. Viomycin is a substitute to use when Streptomycin is too toxic or the organisms have become resistant. At present more drugs of this type are needed for the occasional case that has not responded well.

In regard to a combination of drugs, it appears that any two of the Streptomycin, P.A.S., or INH medications is about equally effective. Used singly all these drugs tend to lose their effectiveness; in combination, they can be used for long periods of time. So far there has not been much favor in using all three drugs at one time, except in cases with bacterial resistance, far advanced disease, or lack of response to two drugs. More work is needed with chronic cases of long standing before a final answer can be given as to whether three drugs are better than two. The problem in use resolves itself in to the question as to whether to use all the effective drugs at one time and overwhelm the infection, or to use two drugs at one time and thereby prolong the period of medication. This is an unanswered question which should be relatively easy to answer by adequate collection of sufficient statistics.

It would appear in the future that the ideal drug would be one than can be given by mouth, and that will be relatively inexpensive, as well as

relatively non-toxic, and that will eradicate the tubercle bacillus in the body. To date none of the present drugs are known to eradicate the tubercle bacillus. Present day drugs are not fully bactericidal. They tend to be bacteriostatic, and merely hold the tubercle bacillus under control for a time.

Much money is being spent in research on new drugs. Many drugs are contemplated and are being explored. This is true of individual drugs as well as certain groups of drugs. Originally we had penicillin as a very effective antibiotic against the pneumococcus, but today we have a wide choice of antibiotics. The authors believe that in the field of tuberculosis the same situation will eventually prevail, even though the tubercle bacillus has been considered for a long period of time to be a relatively resistant organism insofar as bactericidal effect is concerned.

Research is most important in the field of tuberculosis. The constant probing of man into the characteristics of the tubercle bacilli to find out the mechanism of respiration, digestion, and reproduction should eventually develop leads that will be important not only in finding new drugs but better vaccines, disinfectants and control measures. Anti-tuberculous drugs should interfere with the chemistry of the tubercle bacillus. It would appear at this time that broad advances are still possible in this direction. To collect and correlate and then apply the myriad small facts about a minute organism, offers an opportunity to finally point the way to a significant advance.

B.C.G. (*Bacillus of Calmette and Guérin*) is our standard vaccine today. This vaccine consists of live attenuated tubercle bacilli given intradermally. Bacilli have been attenuated by being grown on a nutrient deficient media for many generations. In large parts of the world today, B.C.G. vaccination alone is practically the only measure used to protect a large population against the tubercle bacillus. This is true because the vaccine is cheap and readily avail-

able. Most countries do not have the facilities that we possess nor is it financially possible to obtain them. The B.C.G. vaccination gives a degree of protection. A vaccine with better response and greater protection is needed. Many new techniques are being tried and have been tried to find a better vaccine.

One must appreciate the great reservoirs of tuberculosis in some parts of the world to realize that if our goal of eradication is to be achieved it must be universal. If at some future date, tuberculosis were to be eliminated in one nation and remained rampant in other nearby nations the disease would be continually reintroduced into the country that had freed itself. If we are to achieve our goal of eradication, attention must be paid to all parts of the world regardless of whether they are highly developed or not. A universal disease requires universal attention. Progress that is made in one country should be applied to those living in other nations.

What is the future of surgery in tuberculosis? At the present time resections are being used more and more with less collapse procedures used. The development of new techniques in surgery, anesthesia, and blood replacement has made operation much safer. The anti-tuberculous drugs have lessened surgical complications considerably. It is now possible to operate on lesions that are better stabilized and have a greater component of fibrotic tissue. Those sites of tuberculosis that remain after surgery have better opportunities to heal than previously, thereby diminishing surgical complications. If we find the ideal drug or drugs then surgery will become less necessary, but until that time it appears a greater percentage of far advanced cases will improve to a point where surgery will enable the disease to become arrested. In very small lesions the trend is away from surgery at the present time because there now appears adequate opportunity for these small lesions to be healed medically. With surgery when badly infected irreparably damaged tissue is removed some functioning tissue is necessarily removed at the

same time. It is important to conserve as much functioning lung as possible and with improved surgical techniques this is possible and should be even more so in the immediate future. Surgery will be with us until tuberculosis can be eradicated in the body by other means. Today it is a most important phase in the elimination of hopelessly diseased areas, which continue to slough off tubercle bacilli intermittently or constantly.

Today we continue to be an area of declining mortality from tuberculosis. The year 1900 showed a death rate of approximately 200 per 100,000 population. Today this death rate is 10-20 per 100,000 and rapidly on the way down. We are prolonging the life of a tuberculous patient but the number of new cases found each year has not declined appreciably. This means that we have more effective treatment but not eradication. What does the future hold? This problem has many facets that require intelligent planning and thought.

Today our tuberculosis hospitals are the centers of treatment of this disease and rightly so. All facilities here are available to best treat the patient. Surgery can be used when needed. Every type can be treated including the far advanced chronic or the terminal case.

At the same time that we have the tuberculosis hospital for treatment we also have a large group pondering the question, "Can treatment be successful at home and how successful?" It is true that some patients may prefer home treatment and that some doctors may be willing to give it at home. Let us stress that at the present time the hospital offers the best opportunity for successful treatment. Certainly where there is a bed shortage, home treatment is important to prevent further spread of the disease and further contamination of those in contact with the patient. It appears that home treatment before hospitalization is not as much favored as home treatment after hospitalization. In some areas of the world, home treatment is being tried while the patient continues to work. Bedrest and good

nutrition continue to be very important in the treatment of tuberculosis. This is true whether the anti-tuberculous drugs are used or not. The problem of the need of bedrest and how much is being evaluated directly and indirectly. The answers are being formulated slowly. The problem of home care and how much is in the same status of evolution as the problem of bedrest.

Home care programs require integration of physician, nurse and clinic. Where the general practitioner treats the patient he needs special skills and knowledge of tuberculosis to achieve a good result. This often means increasing education and experience.

Fewer cases are relapsing today on discharge from the hospital than every before but even with the very best treatment available there are some relapses. The poorer the treatment available and the shorter the course of therapy the more the tendency to relapse. The fact that there are relapses indicates that today's treatment is not the ultimate and that better therapy is needed. The patient with far advanced chronic cavitary tuberculosis who takes one drug at a time and then intermittently and refuses adequate rest and good food is the most likely to relapse. New drugs fortunately so far have been introduced at a fairly rapid pace and have enabled us to keep up fairly well with the patient who has developed resistance to one drug or another. Whether this pace of development of new drugs will hold for the immediate future is conjectural.

The problem of contagion of tuberculosis has always been admitted and it is for this reason that State Health Departments by direction of the State Legislatures have taken a hand in control. Today the problem of contagiousness of the treated case is unsolved. There is some evidence in animal experiments that treated cases are less contagious than those untreated. This may be due to the fact that there is less cough and sputum in a treated case but it is more likely to be due to the fact that the anti-tuberculous drugs have an effect on the tubercle

bacillus. Animals can be infected from positive sputum cases under treatment but apparently less readily than from those not under treatment. This factor may create safer nursing of the tuberculous patient but still does not permit the relaxation of safety measures. Many attempts are being made to evaluate more precisely this factor of less contagiousness in the treated case.

There is need for further case finding endeavors despite improved treatment and declining mortality. In some areas, particularly with the Federal Government, case finding programs are being curtailed. Such programs were carried out in cooperation with "State" and "Local governmental" units. This decreased case finding might make it seem that less cases are occurring. In order to meet the final goal of eradication of tuberculosis, it is necessary to know where every case is, and ascertain that adequate treatment be given. Case finding activities today are most important in the high incidence groups, especially those who have been in contact with positive sputum cases, the elderly, the poor, the sick, the closely housed, and the institutionalized. Survey facilities are available to those groups in Maryland today and more emphasis needs to be put on x-raying such groups. As cases become harder to find, the cost of finding each case will be greater.

The tuberculin test at present is little used in survey activities but potentially it is a very useful tool. Our population has fewer positive tuberculin cases each year in the high school survey groups. This would indicate decreasing contagion. If the cost of case finding by x-ray becomes too great, there is a possibility that in the future, tuberculin tests will be done first and only those positive will be x-rayed. We are finding other pulmonary diseases that mimic tuberculosis due to other forms of infection. Many of these are tuberculin negative and this test is very useful in separating this group from the tuberculous. This valuable test needs to be used more as it is simple and easily done, and



should be considered before more difficult and expensive tests are suggested.

Legislative action is needed to strengthen the laws for tuberculosis control. This is especially true for the small percentage of recalcitrant patients who carelessly spread their disease to others. The positive sputum case in the community who refuses treatment and carelessly contaminates others needs to be isolated from the community. At first all attempts should be made to secure the patient's cooperation by education but should this fail, stronger measures are needed. Public opinion must rally behind this effort if it is to succeed. The Tuberculosis Committee of the Medical and Chirurgical

Faculty has made a specific recommendation for strengthening and enforcement of laws dealing with the recalcitrant.

It is good to be living at a time when we can observe great advances in the treatment of tuberculosis. However, this is not a time for smug contentness. The battle to eradicate tuberculosis, while favoring us, is far from won. We have better tools and better methods but years of application are needed to achieve the final goal.

*Mt. Wilson, Maryland  
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*Mt. Wilson, Maryland  
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## THE SHOCK THERAPIES

JOHN D. PATTON, M.D.<sup>1</sup>

One of the major advances in psychiatric therapeutics was made with the discovery of the so-called "shock therapies." In the almost twenty years that have followed, the psychiatric literature has contained many confusing and controversial reports pertaining to these forms of treatment. It is the purpose of this paper to present a brief review of what is known and accepted by the majority of psychiatrists in regard to the "shock therapies."

The terms "shock treatment" or "shock therapy" are usually used to refer to what should more properly be called Electroconvulsive Therapy and Insulin Coma Therapy. ECT<sup>2</sup> is the use of an electrical current to produce a convulsion. ICT<sup>3</sup> is the use of insulin to induce hypoglycemic comas. It is clear that these forms of treatment are a most valuable adjunct in the

treatment of psychotic states. It is still unclear how these treatments achieve their effectiveness, but it does seem that they are operative at a symptomatic level rather than at an etiological level.

The best clinical results with ECT have been noted in patients with depressive symptomatology. ICT seems to be of value in the treatment of the schizophrenic reactions. The use of these forms of treatment has resulted in increased rates of remission and in shortening the length of hospitalizations. On the other hand, there may arise many abuses and complications with the use of these treatments. It cannot be stressed too strongly that these forms of treatment are adjunct therapies. Psychotherapy, and a plan of psychiatric treatment, using all facilities which might be available, remain the first line of attack upon psychiatric reactions. ECT or ICT never solve the conflict with which an individual might be struggling and they do not prevent relapses nor recurrences of mental illness. The use of ICT or ECT to

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<sup>2</sup> Electroconvulsive Therapy will hereafter be abbreviated to ECT.

<sup>3</sup> Insulin Coma Therapy will hereafter be abbreviated to ICT.



the exclusion of other forms of psychiatric treatment and management only leads to disappointing results, with a high relapse rate and an increase in chronic reactions. Any plan of medical treatment must concern itself with etiology and the avoidance of disability, with a consideration of the total person and the environment in which the person lives.

These treatments evolved upon an empiric basis. In 1933 Sakel, of Vienna, reported upon the use of insulin coma therapy. Two years later Von Meduna, of Austria, reported on pharmacological methods to induce convulsions as a treatment for schizophrenia. He found that Metrazol was the most satisfactory agent. Then in 1938 Cerletti and Bini, of Rome, reported on the use of an electrical current as a convulsive stimulus. In the years that have followed, the use of electricity as a convulsive stimulus has almost completely replaced the use of Metrazol.

Experience with these forms of treatment has continued to show that ICT can be effective in the treatment of schizophrenic reactions. The results in schizophrenic reactions treated with ECT have been poor. However, ECT has been found to be effective in the treatment of affective (depressed or agitated) reactions. In the involutional psychotic reactions, where the classical agitated depression is seen, it has been found that through the use of ECT the duration of the depression is shortened, the incidence of suicide decreased and recovery rates increased. In the manic depressive reactions, depressed type, ECT appears to slightly increase the recovery rate but the duration of the depressive episodes is shortened and the danger of suicide decreased. ECT does not prevent subsequent attacks, nor does it alter the frequency of the depressive episodes. Paradoxically, ECT may also shorten the non-psychotic interval between depressed episodes.

In depressions associated with organic brain disease, such as that found with senility and cerebral arteriosclerosis, ECT may be of benefit in alleviating the depressive symptomatology.

In manic depressive psychosis, manic type, the manic episode may be shortened by the use of ECT. As with manic depressive reactions, depressed type, ECT does not prevent subsequent attacks nor does it alter the frequency of the recurrence of manic episodes.

In schizophrenic reactions, where affective elements are present to a large degree, ECT may relieve the affective symptomatology. ECT may be of value as sedation in the management of chronic excited patients. The most common use of ECT with schizophrenic reactions, and one of its greatest values, is to achieve sedation in extremely excited patients who are in danger of exhaustion through a combination of poor physical health and overactivity. Here ECT may prove to be a life-saving measure. On the other hand, the use of ICT with schizophrenic reactions seems to increase the recovery rates, although it does not prevent relapse or recurrence of the reaction. In patients who do maintain their recovery, the span of hospitalization is frequently shortened.

In psychoneurotic reactions, psychophysiological reactions (psychosomatic states) and personality disorders (behavior disorders), neither ECT nor ICT have proved to be of value. It seems probable that their use is contraindicated. One possible exception is in the treatment of psychoneurotic reaction, depressed type (reactive depression). If these reactions have remained refractory to other treatment, and there is a marked suicidal risk, ECT may help the patient to achieve a satisfactory recovery.

There have been many attempts to correlate clinical observations and various test results with prognostic signs. The search has been for certain positive findings which may point out specific indications for ECT or ICT. However, any prognostic sign or test which indicates favorable recovery, means that the patient will probably recover, no matter what the treatment is. As yet there is nothing which will point up specific indications for ECT or ICT.

ICT must always be administered in a special unit in a hospital setting. It requires the presence of well-trained personnel who are competent to recognize the types of reactions and equipped to deal with the complications that may arise. The amount of insulin required to induce a hypoglycemic coma varies from patient to patient. Initially the doses are quite low and are gradually increased to the point where the patient has a hypoglycemic response and then the doses are adjusted to the patient's reaction. In hypoglycemic coma, various stages or levels of symptoms occur in regular fashion according to the level of central nervous system inhibition. At the stage of beginning medullary inhibition comas are promptly terminated. If complications arise at an earlier stage, comas are always promptly terminated. The task of terminating the coma is a different matter than the induction of coma. The first line of attack in termination is the intravenous administration of hypertonic glucose.

The major problem is the termination of the coma which persists after the termination of the hypoglycemia. This calls for expert and special management. The so-called irreversible coma, or prolonged stupor, is a major problem which may end in death.

Frequently patients develop "spontaneous" convulsions with ICT. These are of two types: The "early" types, which are generally without danger, and the "late" or "deep" type which seems related to a too prolonged or a too deep coma. They are a sign of danger and call for prompt termination of the coma. Frequently irreversible coma follows and requires special treatment.

All sorts of physiological cardiac mechanism disturbances are seen in patients with hypoglycemic comas. Variations beyond the so-called normal treatment limits call for termination of the reaction and possibly the cessation of further treatment. Patients in whom there is any evidence or apparent possibility of cardiac difficulties should not be treated.

The other serious complication is the development of insulin allergy. Allergies developing in the course of treatment call for cessation of treatment and perhaps subsequent testing to see if another brand of insulin can be found to which the patient is not sensitized.

Fractures or dislocations may result from overactivity or convulsions. At times ECT is given to a patient in a coma and it may result in fractures. Usually these complications necessitate the cessation of a course of treatment.

A course of treatment usually consists of induction of coma five days a week for an average period of ten weeks. Some patients receive more treatment and some less, depending upon the patient's individual response.

In recent years there has developed a tendency to combine ECT with a course of ICT. A course of about ten ECT are given over a period of two or three weeks near the end of a course of ICT. The ECT is given while the patient is in a "light" stage of coma.

The aim and technique of ECT is quite different. There have been a number of varying reports of experimentation with variations in the type, the amount, and the time of current stimulus. The aim of this experimentation has been to minimize the complications and side-effects. The results reported vary a great deal and there seems to be no agreement as to the usefulness of these variations.

An ECT machine is simply an electronic timer which is supplied with alternating current from an ordinary house circuit. In the standard technique, voltage may be varied from 50 to 150 and the time of current flow from a tenth of a second to one second. Usually 120 volts for 0.5 second will satisfactorily produce a convulsion. The electrodes are placed bilaterally on the patient's temples in the fronto-parietal region. Treatment is usually given in the morning, three times a week. In manic or excited states, several treatments may be given each day. After a patient improves, the frequency of treatment is diminished. The number of

treatments necessary to achieve remission is variable; it may be as low as one or as high as 30, but usually about 10 treatments is sufficient.

Treatments are administered in a special treatment room which is provided with equipment for handling emergencies which can and do arise. As has been mentioned, many variations in technique have been tried in an effort to lessen the complications and unpleasant after-effects. However, all too frequently these variations only introduce a new hazard or eliminate the potential therapeutic effect.

The unpleasant side-effects and complications are grossly of two types, psychological and physical. Among the psychological complications there is a relative amnesia which does not just include psychonoxious material. However, the amnesia is usually minimal and reversible. Psychonoxious material usually remains repressed, the usually conscious information is gradually recalled. After every treatment the patient is confused and requires a period of re-orientation. However, at times this confusion comes to take on the aspect of a "deleroid" or organic-like state, and requires cessation of all treatment. These confusional states are self-limiting and clear up in about ten days. Frequently the anticipation of the treatment, or the actual treatment itself, mobilizes panic states which are more disturbing than the reaction for which the patient is being treated.

The second large area of complications is that of a physical nature. Careful pre-treatment examination should point up the potential areas of danger. With this, the physical contraindications can be weighed against the psychological indications. Quite often prophylactic medical treatment can be instituted to minimize the physical risks. The most frequent complications seen are the vertebral fractures which usually occur with the first treatment. It does not seem possible to predict, nor absolutely to prevent, these fractures which are, for the most part, asymptomatic. The commonly accepted incidence of vertebral fracture with ECT is about

20%. These fractures do not necessarily prevent continued treatment. After a two or three week interval, treatment can be re-started if it seems psychiatrically indicated. In such instances, muscle relaxants are frequently used. Fractures of the long bones occur extremely rarely.

Complications of the respiratory system are of two types. Apnea of central origin occurs with each and every treatment and frequently persists after the cessation of the convulsion. The persistent apnea calls for artificial respiration and the administration of oxygen. Curare only serves to increase the problem of apnea. The second type of respiratory complication is disease process of the lungs, which may be activated incidental to the convulsion. This occurs at times with patients who have, or have had, tuberculosis and receive ECT.

Cardiovascular complications can also occur. There are a few reports where patients with chronic endocarditis or myocarditis have died following treatment. There seem to be no reports of any instance where the first attack of coronary artery insufficiency has followed ECT. With every treatment, however, there are certain vagotonic effects. The routine administration of atropine prior to treatment may inhibit this effect. The muscular contractions and peripheral vasoconstriction caused by the convulsion result in venous congestion and increase the cardiac strain. Again curare seems to further increase these difficulties.

With ECT the usual reported fatality rate is about one-tenth of 1% of the patients treated. The reported fatality rates with ICT may range from about a half of one per cent to one and a half per cent.

Regarding the physical contraindications to the shock treatments, we have to consider in addition to the above mentioned complications the patient's present physical status and his previous medical history. Against this we must weigh the psychiatric indications for treatment. It appears that there are no absolute physical contraindications to ECT. The absolute physical

contraindications to ICT have already been mentioned. In terms of these factors, each patient must be evaluated, individually, with regard to his overall physical status, the severity of his psychosis and the urgency of the need for treatment.

In recent years there has been an increase in the use of ambulatory ECT. This is the administration of ECT in a non-hospital setting, either in a doctor's office or in a clinic. During such treatment the patient lives at home. There have been many controversial statements made about this form of treatment. The potential advantage is that this may obviate the necessity of treatment in a psychiatric hospital. However, the disadvantages are that there might be a lack of precautions against complications and that there is less supervision of the patient. This is especially important to remember when one realizes that with each ECT there is a post-confusional state. A further concern is that ECT may be used routinely and immediately as the sole therapeutic agent to the exclusion of psychotherapy and a complete psychiatric program. There is no doubt that with selected patients, ambulatory ECT is satisfactory, provided there are adequate safeguards. It may be that the greatest usefulness of ambulatory ECT is in the management of certain chronic psychotic states where the administration of ambulatory ECT may make possible an extra-hospital adjustment.

It still remains unclear how ECT or ICT achieve their therapeutic effect. In both forms of treatment there are certain transitory brain changes. With ECT, EEG changes may be found for as long as six months. There seems to be no permanent brain damage except as an infrequent, undesirable complication. There are certain physiologic changes that do occur with both forms of treatment. Whether these changes result in, or from, the stimulation or inhibition of impaired cerebral functioning is also unclear. Furthermore, these physical treatments mobilize powerful emotional reactions. With each treat-

ment a somatic crisis is induced. It is well known that a non-specific somatic crisis developing in a person with a psychiatric reaction will frequently lead to profound psychological changes in the direction of normalcy. Patients undergoing these forms of treatment often report experiencing "a death threat," or "dying and coming alive." It may well be that the word "shock" is appropriate in that we frighten or scare our patients back to normalcy.

Although these psychological factors occur, they may only remotely be involved in producing the remission. In studying the various reactions of patients who have been subjected to these forms of treatment, it becomes only too clear that there is no distinction between mind and body. Rather, the complex interrelationship between mind and body becomes extremely clear.

So far the author has tried to make clear that ECT and ICT can be valuable adjuncts in the treatment of certain psychotic states. One of the basic premises of modern psychiatric thinking is that psychiatric reactions can best be understood as an individual's attempt to deal with the stresses of life, whether they are of a physical, environmental or intrapsychic nature. ECT or ICT, although they may break up or interrupt maladaptive responses to stress, do not solve the problem of why this particular person, with this particular life history, has reacted in this particular way in this particular life situation.

It is believed that ICT or ECT are only indicated as adjuncts in the management of psychiatric emergencies or as adjuncts in a comprehensive psychiatric treatment plan. This plan must include a psychotherapeutic approach where there is a mutually collaborative effort between physician and patient to help the patient achieve adaptive responses with healthier and happier interpersonal attitudes and relationships.

Unfortunately, trends in the direction of prompt, immediate treatment with ECT or



ICT have developed, to the exclusion of a more rational, comprehensive plan. The trend in this direction has resulted from the very natural desire to alleviate human suffering as promptly as possible and to obviate the emotional, social and economic distress of more prolonged treatment, perhaps in a psychiatric hospital. Another influence is that many people can only conceive of treatment in terms of "doing something" of a physical nature. Irrational prejudices often manifest themselves against any approach or treatment where a visible cause and effect relationship cannot be immediately and visibly demonstrated. Such prejudices are rationalized with the statement that "nothing is being done" or that doctor and patient are indulging in a "luxury," or that such efforts are "a waste of time."

It must be stressed that even the most ardent ICT-ECT enthusiasts state that those patients who recover without "shock therapy" seem to make better recoveries with less likelihood of relapse. In other words, the recovery of non-shock treated patients seems to be of a better quality. In dealing with psychiatric problems, treatment does consume a great deal of time and is slow and tedious. However, one of the most important therapeutic attitudes toward psychiatric patients is that of patience, so that the sick person has enough time to make their necessary readjustments.

For some years now, about 20% of the admissions to the Sheppard and Enoch Pratt Hospital have been treated elsewhere with ICT and/or ECT. Prior to coming to Sheppard-Pratt these patients were treated with the appearance of the first signs of emotional disturbance. In the treatment of these ICT and ECT failures, a slower, less drastic approach frequently leads to remarkable recoveries.

It is perhaps worth mentioning that there seems to be a proper time and an improper time to administer ECT or ICT. If ECT or ICT are at all indicated, they will achieve an optimal effect if applied at what seems to be an appro-

priate time. This time seems to be when the patient is ready to "give up" his maladaptive reaction but is unable to do so because he is "out on a limb" or caught in a "vicious circle."

Even the most ardent ECT-ICT enthusiast will state that ICT-ECT treated patients should also be treated psychotherapeutically. However, it must be realized that the shock therapies make the usually difficult task of psychotherapy infinitely more difficult. These treatments mobilize so much fear and anxiety that a therapist's efforts have to be mainly directed at handling the treatment-generated fear. Shock treatments also result in confusion and forgetfulness that may make collaborative investigative efforts impossible. Furthermore, with ECT and/or ICT, there results a repression, or constriction of mental content that hampers psychotherapeutic efforts. In connection with this, it does seem that patients treated with ECT or ICT are "conditioned" to handle conflictual situations by repressing or forgetting the situations, the issues involved and the alternative responses. This results in a frequent observation that these patients seem rigid and stereotyped, with a seeming loss in adaptive capacity. In consequence of the above mentioned factors, the majority of the reports that deal with the psychotherapy of ICT or ECT treated patients, suggest a supportive, non-investigative type of approach. However, with skillful management, a great many people believe that considerably more can be done with these patients. Frequently ICT or ECT seems to facilitate the removal of affective or intellectual barriers which impede the psychotherapy of psychotic reactions. It is suggested here that intensive psychotherapy and shock therapy are not of necessity mutually exclusive, as is usually claimed, but there may be instances where they are.

It is hoped that the following brief clinical reports will concretely illustrate some of the uses and the difficulties involved with these forms of treatment. The first three reports deal with fairly typical situations in which ECT and



ICT have proved of great value. The fourth report will be somewhat longer and will point up many of the difficulties involved and how this particular, somewhat exceptional situation, was handled.

**CASE I.** A man in his early fifties was admitted to the Sheppard and Enoch Pratt Hospital as a transfer from a general hospital. He had been admitted to the general hospital for an emergency major abdominal operation. In the course of an apparently uneventful physical convalescence, he became disturbed emotionally. This progressed to a full-blown manic excitement which required transfer to a psychiatric hospital.

Twenty years previously this man had had a similar excitement without any apparent precipitating stress. Then he was treated in a psychiatric hospital for about two months and made an apparently excellent recovery without any ensuing difficulty.

At the time of his admission to Sheppard-Pratt, he presented a typical picture of manic excitement. Physical examination and laboratory studies at this time revealed no other findings than those incidental to his operation from which he was recovering. Within 72 hours, the clinical picture shifted somewhat. The patient became semi-stuporous, refused all food and required seclusion. In the seclusion room he rolled about and became combative at the approach of personnel. He was unresponsive to any of the various modalities of management which were tried. Tube feedings became necessary. In the next several days the patient developed a gluteal abscess and began to show ankle edema of unknown origin. Laboratory studies indicated dehydration and a beginning uremic state. It was decided to begin this man on ECT. Following the first treatment he began to eat. After the second treatment he began to talk and it was possible to remove him from seclusion. After the fourth treatment he presented physical symptoms and findings suggestive of a thrombophlebitis, and ECT was stopped. In the next two weeks on combined medical and psychiatric treatment, all signs of physical and mental distress abated. The patient continued to convalesce over a four week period. During this time he gradually took part in all the hospital activities. At the end of six weeks he was discharged as recovered and has continued to do well since then.

**CASE II.** A young man of 20, a student in a leading university, became markedly disturbed with a typical acute schizophrenic excitement. He was admitted to Sheppard-Pratt and required treatment in the disturbed unit. Past history revealed that over the previous three years he had shown a gradual change in behavior and there had been several extremely short-lived, acute

schizophrenic episodes. In the course of about a month's time his excitement abated and he was able to move to a semi-convalescent unit. However, he remained rather apathetic, withdrawn and preoccupied, with many autistic fantasies. It seemed that this young man was headed for a lengthy hospitalization with a somewhat doubtful outcome.

At this point it was decided to begin him on a course of ICT. Over the next three months he received approximately 50 ICT and showed a rather typical improvement. His apathy dropped out and he became much more a part of the hospital community. He talked at great length with his doctor about his fantasies and they, and his disturbed behavior, became understandable as ways of dealing with many feelings of inadequacy and inferiority. The major theme of his life seemed to be a competitive struggle to match the success of his father and several older brothers.

Following the termination of his ICT he moved to an open hall and gradually resumed the full responsibility for the direction of his life. During this time he formulated much more realistic plans for his future, both socially and vocationally. Following his discharge from the hospital, he continued to do well and according to reports from both the patient and his family, he seems to be happier and healthier than he has ever been known to be.

**CASE III.** A married woman in her early 60's was admitted to Sheppard Pratt in a rather typical depression. This depression seemed to be precipitated by the combined emotional and physical problems of growing old. This depression was typical in that the woman expressed many nihilistic ideas with many somatic delusions. Prior to her hospitalization she had made a suicidal attempt which narrowly missed succeeding. Following her admission she continued to attempt suicide. She seemed headed for a lengthy hospitalization in which there was a very grave possibility that she might succeed in killing herself. She was promptly begun on ECT and in the course of four weeks received ten treatments. During this time, and the month that she remained in the hospital after the termination of ECT, she had a fairly typical course during which she talked over with her doctor many of her real life concerns which particularly seemed to center about the fact that after a life of devotion to her family, she found herself with little to do and the family uninterested. She also presented a certain loss of intellectual facilities which made it difficult to pursue some of her ordinary interests. In her period of convalescence she developed many new social and avocational interests which seemed to fill some of the real void that existed in her life. She has appeared to do well following her discharge.

CASE IV. A young man had a schizophrenic reaction at the age of 12 which required hospitalization in the Children's Division of a psychiatric hospital. At this time he made several uncontrolled, murderous assaults upon various people. He was given a series of 10-15 ECT and made an apparently satisfactory recovery. Much later he reported that he was terrified with the ECT that was given at this time and thought the shock treatments were being used to kill him. However, he reported that the doctor who administered the treatments seemed to be a friendly, kindly person who was not at all like an executioner. This perception of the doctor led the patient to believe that the treatments were probably not designed to kill him and hence he felt reassured.

Later he made a marginal adjustment in the community for about six years. He was able to go on with his schooling in part aided by psychotherapy.

At 18 he had another acutely disturbed psychotic episode. All of his old psychotic ideas and behavior returned and he was rehospitalized in a different hospital. In the course of this reaction he was transferred to a second hospital. In both of these places he continued disturbed and unresponsive to treatment. As a result, he was given innumerable ECT and combined ICT-ECT. Throughout this period he remained unimproved. Much later he reported that the doctors who administered these treatments, in both hospitals, acted as if they meant to kill him. They did not seem at all like the warm, friendly doctor of the first admission. The patient also reported that when ECT and ICT were administered, he felt a great deal of sexual stimulation. During the process of these treatments he would become unconscious and frequently had to be made to submit to the treatment through force. Because of these facts, he came to the conclusion that he was being sexually assaulted during the treatment. He remained unimproved and finally the hospital informed his mother that she would have to consent to a pre-frontal lobotomy or remove the patient from the hospital. At this point his mother arranged his admission to Sheppard-Pratt. This was after a period of two years of continuous hospitalization and innumerable ECT and combined ICT-ECT.

At Sheppard-Pratt he remained extremely disturbed and assaultive but no ICT or ECT was administered. His disturbed behavior resulted in his injuring himself. At this point he was given large doses of chemical sedation and kept heavily sedated over a period of several weeks. While sedated he was put to bed and given a great deal of "special attention." Although he was helpless at this time, he began to feel, for the first time, that he was not being tortured or murdered. It became possible to discuss with the patient his real life situation

which precipitated his psychotic reaction. This was a situation which would have terrified anyone. The patient began to show improvement and with this his sedation was stopped. After the cessation of the sedation, he had a "spontaneous" seizure. For some months he remained periodically upset with many psychotic ideas and a good deal of psychotic behavior. However, he had begun to establish many meaningful interpersonal relationships and as he progressed he was able to move through the convalescent units of the hospital. Six months later he was discharged after having shown considerable progress with a much better degree of integration and much more strength to handle the issues of real life. He has been followed for two and a half years after his discharge and has been treated with intensive psychotherapy. He has made tremendous progress to the point of becoming financially self-sufficient and is about to finish his college education. He has reported amnesia for a great many events, claiming he cannot remember them because they occurred during the time of ECT. He finally reported to his doctor, "You know, doctor, I remember some of the things from that time and I don't remember other things." Some months later his statement was to the effect, "It seems I recall the things I want to remember and don't recall the other things." With this patient it was frequently the "good" things which were forgotten and the "bad" things which were recalled. Still later he said, "You know, doctor, it seems I can remember all the things I say I can't remember but it does seem whenever anything upsets me, I just seem to blank out."

#### SUMMARY

Shock therapies are a valuable adjunct in the total, overall treatment of psychotic reactions. There is no evidence to indicate that they are of benefit in non-psychotic states with the possible exception of psychoneurotic reactions, depressed type, that have not responded to more conservative treatment. The use of these treatments frequently results in an increased rate of recovery with a shortened period of hospitalization. However, there are many complications and unpleasant side-effects, both psychological and physical, which arise with the use of these treatments. Some attempt is made to show how the "shock therapies" can be integrated into a program of total psychiatric care.

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# Baltimore County



# Health Department

*Community Health Through Individual Effort*

## THE VOLUNTARY HEALTH WORKERS OF BALTIMORE COUNTY

MR. WILLIAM A. ROWE, *President*

WILLIAM H. F. WARTHEN, M.D., M.P.H.,\* *Member*

In the spring of 1922 when the first full time Health Officer came to Baltimore County, a committee, composed of physicians and laymen, was organized to work with him. This committee consulted the leading health authorities in the country, the Johns Hopkins School of Hygiene and Public Health, the State Board of Health, the Maryland Tuberculosis Association and the Baltimore County Medical Association. The movement had the endorsement of the Medical Association. In October of 1922, the committee met at the Court House to place before the County Commissioners their plans for the formation of the Baltimore County Public Health Association to carry on the public health nursing service that had been inaugurated by the American Red Cross in Baltimore County. Following the report of this committee, actually on November 15, 1922, the Baltimore County Public Health Association was organized, and was incorporated four years later in 1926.

The first health center was equipped and opened for service in the Old Armory in Pikesville in 1923 through the efforts of the late Miss Katherine Craddock and a public health nurse was provided for serving the community. Shortly thereafter, the Randallstown Health Center was built; the center consisted of one room on school property. The public health nursing service was provided for the community. The Randallstown Health Center came into being largely through the renowned pioneering efforts of the late Mrs. John K. Ruff.

Perhaps the first rural nurse in Maryland was she who worked in Catonsville. The Instructive Visiting Nurse Association of Baltimore had placed this

nurse in the field in 1911, sending her to Catonsville and Ellicott City on the street car, where she walked and carried her bag, visiting the homes in the area. At the end of the year, the Women's Civic group of Catonsville took over the support of the nurse. With the formation of the Baltimore County Public Health Association in 1922, the Women's Civic group became the first district public health association to join the new County agency. Through the years, interested citizens in many areas of the county met to talk over their problems, formed health committees, studied their health needs and devised ways and means of meeting these needs and then joined the County organization. Thus, the Baltimore County Public Health Association had its beginnings and grew.

Today, the Baltimore County Public Health Association has sixteen component community groups some called district health committees and others public health associations. These groups maintain or help to maintain health centers in Catonsville, Randallstown, Pikesville, Reisterstown, North Baltimore County, Cockeysville, Towson, Fork, Dundalk, Turner, Halethorpe, Overlea, Essex, Middle River, Sparrows Point and Chase. Some of the Health Centers are pictured on the following pages.

Each one of the sixteen component community groups or district health committees has its own officers and functions autonomously, working quite closely with the public health nurses in the area. The Board of Directors of the Baltimore County Public Health Association is elected annually to serve one, two or three years. The component community groups, that is, the district committees, have their ties with the County-wide organization by way of the district chairmen or presidents, who are elected to the Board of Directors. There are nine directors elected, representing the following organizations: The Baltimore County Medical Association, the Woman's Auxiliary to the Baltimore County Medical Association, the Medical Services of the State Tuberculosis Hospitals, the Maryland Tuberculosis Association, the

\* The Board of Directors and the Executive Committee, Baltimore County Public Health Association.



FIG. 1

**No. 1—MIDDLE RIVER HEALTH CENTER**

Left to right: MISS CAROLINE BARTLETT, Public Health Nurse; MRS. DOROTHY SADLER, Public Health Nurse; MRS. ALMA BROWN, Chairman of Health Committee.

**No. 2—ESSEX HEALTH CENTER**

Left to right: MRS. EVELYN MORAN, Public Health Nurse; MRS. VIRGINIA BORSOS, Member of Health Committee; MRS. BETTY JANE EDGAR, Public Health Nurse; MISS JUNE CALVERT, Public Health Nurse; MRS. ALICELEE KLEIN, Public Health Nurse; MRS. MARTHA LARUE, Vice-President of Health Committee.

**No. 3—SPARROWS POINT HEALTH CENTER**

Left to right:  
(Front row): MISS MILDRED WALTER, Public Health Nurse; MISS ELIZABETH STREETT, Public Health Nurse.  
(Middle row): MRS. HORACE WOODRUFF, Chairman of Health Committee; MRS. LINFORD PRESTON, Treasurer of

Health Committee; MISS KESSEY LARRIMORE, Public Health Nurse.

(Back row): MRS. JOHN GIBSON, Secretary to Health Committee.

**No. 4—CATONSVILLE HEALTH CENTER**

Left to right: MRS. V. T. DOUGLAS, Chairman of Health Committee; MISS LILLIAN HISS, Public Health Nurse; MRS. JEANNE HOOVER, Public Health Nurse; MRS. FRED ANDREAEE, Member of Health Committee; MRS. HENRY S. HERBERMANN, Member of Health Committee; MRS. VICTOR G. BLOEDE, JR., Member of Health Committee; MRS. ANTHONY ORBAN, Member of Health Committee.

**No. 5—DUNDALK HEALTH CENTER**

Left to right:  
(Front row): MRS. LAURA BIERLEY, Public Health Nurse; MRS. CHARLOTTE FISHER, Secretary to the Health Center.  
(Back row): MRS. GWENDOLYN SNYDER, Public Health Nurse; MRS. PAULINE DAILEY, Public Health Nurse.





FIG. 2

## No. 6—PIKESVILLE HEALTH CENTER

Left to right: MRS. JANE LITTLE, Member of Health Committee; MISS PATRICIA MALICK, Public Health Nurse; MISS CLAIRE KEARNS, Public Health Nurse; MRS. EVELYN ENGLISH, Member of Health Committee.

## No. 7—RANDALLSTOWN HEALTH CENTER

Left to right: MRS. GRACE LOGAN, Public Health Nurse; MRS. HARRY PARSLEY, Member of Health Committee; MISS BERNICE KEEFER, Public Health Nurse; MRS. HARRY WEIDMAN, Chairman of Health Committee; MRS. JOSEPH HOHMAN, Member of Health Committee; MRS. HENRY ADAMS, Member of Health Committee.

## No. 8—COCKEYSVILLE HEALTH CENTER

Left to right: MISS MARIE SWORDS, Public Health Nurse; MRS. DOROTHY HUTCHINS, Public Health Nurse; MRS. DORIS HAHN, Public Health Nurse.

## No. 9—HALETHORPE HEALTH CENTER

Left to right: MRS. LUCILLE ROEDER, Public Health Nurse; MRS. GERALDINE KURAPKA, Public Health Nurse; MRS. YVONNE HARDY, Secretary to the Health Center; MRS. BEULAH TRIPLETT, Public Health Nurse.

## No. 10—REISTERSTOWN HEALTH CENTER

Left to right: MISS CATHERINE MCKENZIE, Public Health Nurse.



Baltimore County Board of Education, the Children's Aid Society of Baltimore County, the Board of Health of Baltimore County and both medical and nursing representatives of the County Health Department. In addition, there are eleven directors-at-large, elected from the membership who have served the organization faithfully and well over many years. Meetings of the Board of Directors are held quarterly and there is one annual luncheon meeting when the entire membership of the Association is invited. Programs on some phase of public health may be presented or problems of a local character are discussed at these meetings.

In 1946 the Baltimore County Public Health Association took over the handling of the annual Christmas Seal Sale for Baltimore County and became an affiliate of the Maryland Tuberculosis As-

sociation. Immediately after this affiliation a Tuberculosis Committee was organized in the Association's directorate in order to formulate policies and to plan the budget and control the disbursement of funds collected through the Christmas Seal Sale. This committee now meets when urgent business requires. Now and since 1946 a full time Executive Secretary and a full time staff of the Baltimore County Public Health Association works in the headquarters office near Towson.

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## OPPORTUNITIES FOR HEALTH IMPROVEMENT AND HEALTH EDUCATION FOR THE SCHOOL CHILD IN BALTIMORE COUNTY

MARY E. MATTHEWS, M.D., M.S.P.H.\*

In the year 1894 simple medical inspection of school children was begun in the public schools of Boston by Dr. Samuel Durgin, a famous health officer of the city at that time (1). The State of Massachusetts in 1906 was the first state to pass a law requiring annual medical examinations of all school children. Since that time many states have copied or modified this law. Through the years there have been many changes in concept as to what should be the function of a school health service.

Along with changing attitudes toward services offered, there have been changes in concept as well with regard to the administration of a school health service. At the present time the organization of choice is generally agreed to be one of a joint enterprise by health and education departments (2). Such is the case in Baltimore

County, where, as explained elsewhere in detail, the Baltimore County Health Department, the Board of Education of Baltimore County and the Department of Catholic Education work together in cooperative endeavor (3). This endeavor has been highly effective largely as a result of the functioning of the School Health Council which is made up of various interested parties who form an advisory and discussion group with those in the health and education departments who are officially responsible for administering the school health program.

There is no law requiring examination of school children in Baltimore County so that the administrators of the program are glad of the opportunity to work along the lines of sound public health thinking throughout the country, that is, that health improvement is not rightly a matter of legal coercion, but one of health education.

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In a recent extensive survey of 140 cities throughout the country it was found that there is no uniformity of employment of school physicians or periodicity of health examinations (4). All of the school systems in the study employ physicians on a part time basis varying from 1 to 15 hours per week and many of the same schools employ full time physicians. Some of the schools require annual examinations, some every three years, some examine children on a referral basis only. A number of school systems require additional education or routine in-service training for their school physicians. In Baltimore County a real effort is made to secure from practicing physicians, within the school community, part time physicians who are interested in working with children and preferably have had pediatric training. Plans have just been completed for a series of seminar discussions with school physicians in order to keep them up to date on new developments and add interest to their work. Seminar discussion concerning history and physical examination of the well child can be very profitable to those physicians who have had previous experience primarily with ill children. In Baltimore County first grade pupils, pupils new to the school system and children referred on the basis of teacher-nurse conferences are examined by the school physician upon the request of the parents.

#### THE DETECTION AND CORRECTION OF REMEDIAL PHYSICAL DEFECTS

In order to give the reader a clear idea of the opportunities for health improvement and health education offered to the parents and children of the public and Catholic schools in Baltimore County, let us follow the course of a typical child among the approximately 8,000 first graders in the 87 elementary schools in the County. The child's first introduction to the school and to the school health services is by way of an invitation to the parents to bring the child to school for the so-called spring preschool roundup or registration. By means of a conference with the

teacher and the public health nurse the parent has an excellent opportunity to discuss any health problems of the child so that they may be brought to medical attention. The parent is urged to take the child to the family physician so that any correctable conditions may be given proper attention before the beginning of school in September.

Throughout the whole school health program there is maintained the principle that the child's own private physician is the one best qualified to give continuing health supervision to the well child as well as to the ill child. To this end letters are written to the private physicians of Baltimore County at the same time that the preschool roundups are in progress, urging them to send recommendations, on forms provided, to the school so that the teacher and the nurse working with the private physician, may help the child achieve optimum adjustment to his new school experience. If the parent signifies that he or she would like to have the child examined by the physician assigned to the school by the Health Department, this opportunity is given to the child during the first school year. For many children, this health examination when the child first enters school will be the first complete physical examination the child has ever had and will lay the groundwork for future cooperative plans. The examination, whether done by the private physician or by the assigned school physician with the parent and public health nurse present, provides a conference which serves as an important starting point for the school and public health nurse to lay out a plan for meeting the individual health needs of the child in his future school career. If not performed by the private physician, and if the parent requests, the child is also offered the opportunity of the first or the "booster" immunizations against diphtheria, tetanus and pertussis.

Continuing health supervision of the child is carried on by means of the teacher-nurse conference early in the first year of school. This conference is repeated for the child each year rou-

tinely and at any time when special need arises. During the first year, and continuing each year thereafter, the child receives the benefit of the screening Massachusetts Vision Test. Parents are notified of the results and urged to seek any necessary medical advice through their family physician. During the third year of the child's school experience he is given a hearing test with a pure tone audiometer and exactly the same procedures followed as in the case of the vision test. The private physician who is consulted in regard to a possible hearing defect has the privilege of treating the child himself, or referring the child to a specialist or to the well staffed conservation of hearing clinic at the Baltimore County Health Department. Audiometric testing is also available in the clinic. In addition to these services, public health nurses and teachers are constantly endeavoring to seek the very important follow-up, with the assistance of the private physician, of remediable physical defects.

#### THE PREVENTION OF THE COMMUNICABLE DISEASES

The primary responsibility for the day-to-day protection of the child from communicable diseases appearing in the classroom is that of the classroom teacher and she, together with the principal, have the authority to send the child home if there is evidence of febrile or communicable illness. In this regard the principal has a close consultative working relationship through the public health nurse with the Director of the Division of School Health Services. By means of this channel medical direction is given and close cooperation between private physicians and the Baltimore County Health Department is maintained.

A copy of the State Board of Health chart, *Requirements for Communicable Diseases*, familiar to and used by every physician of Baltimore County, is in every school. This chart is used as a basis of referral by the principal and teachers. The subcommittee of the School Health Council to study methods relative to the handling of the

communicable diseases in the schools meets when necessary to suggest policies. Out of the discussions in this subcommittee and as the result of conferences with private physicians, a school *Health Bulletin* is issued every week by the Director of the Division of School Health Services. This *Health Bulletin* is sent to all principals, practicing physicians, to all public health nurses, as well as nurses in the high schools, and to all parent-teacher groups. The publication contains timely information about communicable diseases, such as source, spread and prevention of spread. The issues in the spring of 1954 were written in an attempt to allay fear, sometimes akin to hysteria, concerning poliomyelitis.

Since the first issue of the *Health Bulletin* early in 1954 scores of favorable comments upon its timeliness and usefulness have been made to the Health Department by both professional and lay groups. It is probably of interest here to reproduce one of these spring issues.

#### BALTIMORE COUNTY HEALTH DEPARTMENT HEALTH BULLETIN POLIOMYELITIS

The only way to combat the disease poliomyelitis is by knowing sources of help, understanding facts about the disease, and following simple precautions recommended by medical authorities. The following questions and answers are intended to help principals, teachers and parents in understanding such facts as are known about poliomyelitis:

1. How is poliomyelitis spread?

Answer: The virus of poliomyelitis has been found in the nose, throat and bowel discharges of patients with the disease, of persons with so mild an attack that it cannot be recognized, and of carriers or persons who are not sick of the disease but who still carry the virus.

The virus is probably spread by droplet infection through nose or throat secretions and is thought to enter the body of a susceptible person by way of the nose or mouth. Usually the disease is thus spread by direct respiratory contact with persons who carry the virus, apparently in much the same way that measles is spread.

2. Does my child have a greater chance of contracting poliomyelitis in camp?

Answer: No. The chances of a child contracting

poliomyelitis in camp seems to be no greater than a child at home. This is a comforting thought for parents and camp directors when nagging fears of this disease invade summer plans. It has been estimated that only once in a century can multiple outbreaks be expected in the average camp or school.

3. What do health authorities think about the use of Gamma Globulin?

Answer: The use of Gamma Globulin in individual instances is a matter to be decided by *your own private physician*. However, decision arising out of extended conferences of State and Territorial Health Officers, the Office of Defense Mobilization, the National Foundation for Infantile Paralysis and the American Red Cross stress the fact that "*No evidence exists that Gamma Globulin is of any value in the prevention or modification of poliomyelitis.*"

4. When poliomyelitis is in the community, should my child have tonsillectomy and adenoidectomy operations or inoculations?

Answer: You should be guided by your physician in answer to this question. He may feel that unless there is some special reason for such procedures, they should be postponed.

5. How long does it take to come down with poliomyelitis?

Answer: It usually takes 7 to 14 days to come down with poliomyelitis after you have been infected with the virus.

6. Do all patients with poliomyelitis need to be admitted to the hospital?

Answer: Some mild cases of poliomyelitis can safely be cared for in the home.

7. What are the chances of a person in Baltimore County developing poliomyelitis?

Answer: During last summer and fall (1953) less than five (5) people in 10,000 developed poliomyelitis.

8. What can we do if poliomyelitis comes our way?

Answer: *Keep children with their own friends.* Keep them away from people they have not been with right along, especially in close daily living.

*Try not to get overly tired by work, hard play or travel.* If you already have the poliomyelitis infection in your body, being very tired may bring on serious poliomyelitis.

*Keep from getting chilled.* Don't bathe or swim too long in cold water. Take off wet clothes at once. Chilling can lessen your body's protection against poliomyelitis.

*Keep clean.* Wash hands carefully before eating and always after using the toilet. Hands may carry poliomyelitis infection into the body through the mouth. Also keep food clean and covered.

*Watch for early signs of sickness.* Poliomyelitis starts in different ways—with headache, sore throat, upset stomach, sore muscles or fever. Persons coming down with poliomyelitis may also feel nervous, cross or dizzy. They may have trouble in swallowing or breathing. Often there is a stiff neck and back.

Until your physician, who is the only one qualified to make the diagnosis arrives, keep the patient quiet and in bed and away from others. Don't let the patient know you are worried. Your physician will tell you what to do. Frequently, it is difficult for your physician to make an early diagnosis.

*Prompt medical advice and care by the physician in all illnesses as well as those suspicious of poliomyelitis is extremely important.*

If the child is exposed to *tinea capitis*, pediculosis, impetigo or scabies, the entire classroom is screened as well as any sibling of the infected child. Found cases are gotten under medical care and are under continued medical supervision until entirely cured.

#### GENERAL HEALTH MEASURES

No discussion of the effort that is made to secure protection for the health of the child would be complete without mentioning the continued supervision of the school environment and personnel. The Health Department serves continually in an advisory capacity in matters of heating, lighting and sanitation in all the schools. Annual inspections are made of school cafeterias by the Baltimore County Health Department and annual chest x-rays of school personnel are provided through cooperation with the Baltimore County Public Health Association, the Baltimore County Health Department and the Baltimore County Medical Association.

#### SUMMARY

During the six years of the functioning of the cooperative school health service in Baltimore



County, it is believed that much progress has been made toward reaching the objectives of a good school health program. The public health nurse and the classroom teacher in cooperation with the private physician are being utilized as key persons toward a thorough integration of health teaching and healthful living in the classroom. This health teaching is built in and around all school health services with children participating in health activities instead of being the old time docile acceptors of needles, weighing and inspections. A number of schools have organized school health councils the members of which discuss health activities and health problems of their own within the school. These school health councils are composed of elected pupils, teachers, parents and the principal. The public health nurse serves in a consultant capacity. Most school health problems have their roots in the home and are linked to the physical and emotional problems of the rest of the family. Parent discussion groups with representatives of the Health Department participating have been conducted successfully as part of local parent-teacher meetings. The public health nurse by steadily dealing with health problems on a family basis, is serving to extend health education into the home and the community and thereby facilitates a complete school health program.

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## COMMUNICABLE DISEASE PREVENTION AND CONTROL IN THE BALTIMORE COUNTY HEALTH DEPARTMENT

J. EVERETT SANNER, M.D.\*

Before the advent of rational medicine, relatively slight importance was attached to the idea of contagion. In antiquity various superstitious views were held, such as that of miasm conveyed through the atmosphere, to account for the origin and spread of endemic and epidemic diseases. This idea survived the authority of Hippocrates and Galen, and has been displaced only in recent times by our knowledge of the living agents of infection.

From writings that have come down to us, we know that principles of sanitation of the environment originating with the Greeks were familiar to the ancient Romans. Following the fall of the Roman Empire came the intellectual decline of the Dark Ages, accompanied by conditions of neglect of personal and public hygiene.

Out of the thousand or so years of mediaevalism, Europe emerged with two ideas of great significance to the public health, e.g. the establishment of hospitals for the care of the sick, and the recognition of contagion as applied to the control of certain epidemic diseases by means of isolation and quarantine.

It was, however, the pestilences of the middle ages—smallpox, plague, leprosy, typhus, and, at the end of the fifteenth century, syphilis—which forced upon the mind of the public the belief in the conveyance of these diseases by human contact. This concept did not find its way into a plan of governmental health activities until certain ideas and suggestions were embodied in the legislation of the middle of the nineteenth century. It was not until 1869 that the first State Board of Health was established in Massachusetts.

Meanwhile, the science of sanitation was groping blindly in the dark before the discovery of the living agents of infection. For a quarter of a century Pasteur had been laying the foundations of modern bacteriology. Technical methods introduced by Koch were adopted by Pasteur and other followers and rapidly led in the "eighties" to that series of discoveries of the organisms causing cholera, tuberculosis, puerperal fever, diphtheria, typhoid fever,

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pneumonia, cerebrospinal meningitis, and others. The spirochete of relapsing fever, the gonococcus of Neisser, and the parasite of malaria were already known. In 1885, Pasteur's work in the field of immunity culminated in his dramatic discovery of preventive inoculation against rabies.

The following decade was marked by the introduction of vaccine and serum therapy and prophylaxis, the distinction between human and bovine tubercle bacilli, and the opening of the highly important field of insect-borne diseases such as malaria, yellow fever, trypanosomiasis, and typhus. The role of human carriers in the transmission of infection also came to light in this decade but full appreciation of the epidemiological problems thereby created did not come until the present century.

Thus, within the past one hundred years bacteriology, by revealing the microorganisms concerned in those diseases which are of the greatest importance to man, and by providing methods for the study of their characteristics and behavior, changed public health from a blundering, empirical set of doctrines and practices to a science, and laid foundations for its further development along scientific lines.

#### COMMUNICABLE DISEASE CONTROL IN BALTIMORE COUNTY

During the rapid population growth of Baltimore County since 1940 under the competent leadership of Dr. William H. F. Warthen, Health Officer, the Baltimore County Health Department has held as one of its chief objectives the prevention and control of the spread of communicable diseases. It has utilized the knowledge gained in the past and kept abreast of the newest discoveries. The efforts of the various divisions of the Department in cooperation with the practicing physicians, the Baltimore County Medical Association, the Baltimore County Public Health Association, the Board of Education, Parent-Teacher groups and other local agencies are directed toward preventive medicine. The infant, the preschool child, children of school age, and adults are protected as far as possible from communicable diseases by reporting, isolation, epidemiological investigation, inoculation and vaccination, chemotherapy, environmental health measures and public education. As a result of these practices many diseases have almost disappeared from our midst and still others are less common and far less severe.

Epidemics of plague, yellow fever, leprosy, cholera, smallpox, typhus, typhoid fever, diphtheria and others are things of the past. Diminution in the high infant mortality of a relatively few years ago, and the reduction in child and adult morbidity have markedly lengthened the span of human life.

The Baltimore County Health Department has always maintained an attitude of helpfulness toward the practicing physicians. Periodic letters are sent to them announcing changes in policy, alterations of certain practices, and information regarding the latest advances in the prevention and therapy of communicable diseases. Among the first of these communications was one in which the control of Rocky Mountain spotted fever, pneumonia, and diphtheria was outlined. Early in 1945, the BALTIMORE COUNTY HEALTH DEPARTMENT REQUIREMENTS FOR COMMUNICABLE DISEASES was sent to all physicians in the County. This chart lists the more important communicable diseases, the incubation periods, the common early signs and symptoms, method of infection, isolation requirements, and remarks. A revision of this useful and informative chart was made in April 1951 and this likewise was sent to members of the medical profession bringing them up to date on the latest concepts of communicable disease control. In 1946, private physicians were informed that immune serum globulin was available to them for use in preventing the spread of measles and that penicillin could be obtained for the treatment of venereal diseases. In 1947, the spring round-up clinics for preschool children were started, and later that year, following an outbreak of diphtheria, the prevention of that disease was again stressed. Two years later a third letter called the attention of the profession to the necessity of diphtheria inoculations in young children. Following a nation-wide conference held in Ann Arbor, Michigan in June, 1949, *Recommended Practices for the Control of Poliomyelitis* was sent out.

In July of 1952, the physicians were apprised of new procedures regarding chest tuberculosis clinics, and in August a memorandum on the use of gamma globulin for the prevention of paralytic poliomyelitis was distributed. In May of 1953, the medical profession was circularized relative to gamma globulin distribution procedures.

A distinct innovation in Baltimore County early in 1954 was the distribution to all private physicians

of a Chart entitled, SUGGESTED PREPARATIONS FOR PROTECTION AGAINST CERTAIN DISEASES—AFTER EXPOSURE. On this Chart is listed the more common communicable diseases, indications for use of material, where available, the cost, the dose, and the time of administration of vaccines, serums and drugs for the treatment and the prevention of certain of the acute communicable diseases. This has proved to be of considerable value to the physicians and has won acclaim throughout the State.

An important memorandum was sent in June of 1953 to all physicians acquainting them with rabies control measures and policies. Later in the year, in November, an outbreak of animal rabies occurred in two scattered areas of Baltimore County. On December 8, with the cooperation of the Maryland State Live Stock Sanitary Service and the Baltimore County Police Department, a dog quarantine was established around those areas for a ninety-day period. Immediately, in a very dramatic fashion, further spread of animal rabies ceased, and no human rabies occurred anywhere in the County. This is a glowing example of what can be accomplished by the prompt and efficient action of an alert health organization.

Over the years private physicians have been encouraged to ask questions regarding the many communications sent them and they have availed themselves freely of this opportunity. Frequent written and verbal consultations between the practitioners and the Health Department staff have been held, and important decisions made regarding the diagnosis and treatment of many specific cases of communicable diseases and their control, thereby adding immeasurably to the efficacy of each, the work of both the physician and the Health Department, and thereby increasing the benefits derived by the individual citizen.

Paralleling the improved well-being of the individual and his increased longevity, the community at large has benefited in many ways. Productivity has increased, employment is more general, public assistance has diminished, and the standard of living has been raised.

#### SUMMARY

A history of the changing concepts of contagion reveals that knowledge of the subject progressed

slowly until the latter part of the last century. With the discovery of the living causative agents of disease, public health advanced rapidly and developed along scientific lines.

The Baltimore County Health Department keeps apace with the newest discoveries and maintains strict vigilance over the prevention and control of the spread of communicable diseases. The campaign has been eminently successful because of the constant cooperation between the Health Department staff and the practicing physicians of Baltimore County. Frequent communications are sent the latter advising them of changes in practices and methods, and many verbal and written consultations are exchanged.

A properly organized and well executed public health program is an essential, if not the most essential, part of a community and this is nowhere more apparent than in Baltimore County.

A markedly reduced incidence of some of the once common, severe, and often fatal communicable diseases has been the result. With the prompt and efficient administration of public health measures, a stage of development has now been reached where it can be safely predicted that many diseases now rampant in the community will be appreciably diminished or prevented. Rapid strides are being made in immunization, and new therapeutic agents are being constantly discovered. The future is indeed bright for mankind and decidedly gloomy for the ills that beset him.

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## PREVENTIVE MENTAL HEALTH IN THE BALTIMORE COUNTY HEALTH DEPARTMENT

VIRGINIA SUTTENFIELD, M.D.\*

Prevention is a major portion of the work of the mental health division of the Baltimore County Health Department—prevention in the sense of helping people make the most of their potentialities in present daily living—prevention in the sense of providing indirectly against future liability to mental illness. That every individual has the right to live a healthy life is the basic tenet of public health administration. This tenet is now broadened to include the emotional well-being of the individual.

This paper will discuss the preventive aspects of the present mental health program with some suggestions for future planning. It is not within the scope of this paper to go into theoretical considerations as to the feasibility of such a program being administered under public health. Dr. Paul V. Lemkau has dealt with these considerations at some length in his book *Mental Hygiene in Public Health* (1).

There are four principles of good mental health which have developed over the years, and are adapted in the Baltimore County Health Department as the basis of the preventive program. The first of these is this: When a person is under emotional stress, if he can *talk it out* with an objective person, he can integrate the stressful experience better, and is less liable to suffer from unhealthy effects from that particular stress. This first principle has been proven to be true, and has been adapted to many fields—all the way from industries (2) who are interested in maximum production, to doctors who are interested in cooperative patients (3). It is used widely in the counselling services of large business houses (4), and has been used by medical social service departments of hospitals since 1905 (5). Being an objective listener has been refined and

taught as a technique in many schools of social work, ministry, psychology and medicine. In the Baltimore County Health Department the public health nurses apply this principle many times a day. Many of them have become so familiar with it that they no longer think of it as a technique but as part of being a public health nurse. For example, the days are over of lining children up for immunization shots as though they were inanimate objects. Nurses talk with the children and their parents. Nurses now recognize that children have different approaches to the experience of "taking shots," and that a "bad" experience for a child can often be made into a "good one" by an understanding nurse. The nurse frequently can help a fearful child talk about his fears, then to observe the behavior of other children under similar circumstances and gradually to dispel the fear. Then what started out as a terrorizing experience can become a successful immunization for the apprehensive child. To reiterate, this principle is applied in many instances and makes the contact between nurses and patients much healthier, from a mental health standpoint.

The public health nurses are also applying this principle in their follow-up nursing service for selected patients from Spring Grove State Hospital. By helping patients talk about the numerous problems in readjustment after hospitalization, they can administer to their emotional as well as to their physical needs.

This same principle of "talking it out" is used in the mental health clinic by the treatment team of social worker, psychologist and psychiatrist. Children and adults are encouraged to talk about their difficulties to a clinic person who has been specially trained in good listening. As one health officer put it: "You're using words to cure people." It is the patient's own words that are

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curative when this first principle of mental health is effective.

The second principle is this: When a person uses his own *initiative* in solving his problems and takes *responsibility* for his actions, this is good mental health. If he cannot solve a particular problem, and yet is able to recognize his limitations and seeks help in solving it, this too is good mental health. This is the principle behind the general trend in social welfare agencies to help clients take care of their own problems, rather than to do everything for them. In the medical profession it underlies the medical care program which, in Baltimore County, is administered through the Health Department with the active cooperation of private physicians, dentists, and pharmacists.

Perhaps it would clarify this second principle if it were contrasted to its opposite. For example, in the days before good mental health, a parent who was concerned about the temper outbursts of a child would have been told authoritatively what to do to the child. This would be done and the temper outbursts might or might not cease. A similar parent today with a similar child might come to the public health nurse or the mental health clinic and talk about the problem to determine some possible causes for the child's outbursts and some different ways of handling the situation with better success. In the first instance, the parent was dependent on the advice-giver to do the thinking and to dictate what should be done, and took no responsibility. In the second instance, where good mental health practices are used, the parent is helped to think for himself, use resources within himself and take responsibility for his own actions.

There is much opposition to this second mental health principle being fully employed. The general search for security "from the cradle to the grave" encourages dependency rather than independent action. Within our own Health Department it frequently is easier to carry out a routine automatically than to think out a problem for oneself. The value of this second

mental health principle is difficult to measure, but is accepted by many leaders in the fields of mental health and psychiatry. There are some research projects in progress to establish its worth (6).

The third mental health principle has not yet been substantiated by thorough research projects but has a wide popular appeal. It is this: That discussing one's ideas and expressing one's feelings *in a group* is good mental health. Group participation dispels loneliness and feelings of isolation. Enough courage can be gained from the support of other group members to enable a participant to come to new realizations, and new insights. When the group is composed of people with similar problems, there is exchange of practical ideas to the benefit of the group. Actually, group methods originated many years ago as a means of dealing with such systemic diseases as diabetes and arthritis. Adult education programs have been using group methods to disseminate factual information and to encourage discussion. Many educators prefer this method to lectures.

The group method has been given great momentum in the Baltimore area by Dr. Jerome Frank (7) of Phipps Clinic, and by the Mental Hygiene Society. The mental health clinic in the Health Department used group methods in 1950 as a means of treating two or more patients at a time and group meetings are an integral part of the Alcohol Study Clinic of the Department at the present time. Recently a public health nurse had the opportunity to meet with four expectant mothers to discuss their pregnancy problems rather than to talk with each woman individually. The nurse had originally thought of the time-saving aspects of the group method rather than the added benefit of group discussion, but it has precedence in a public health program (8).

As a mental health principle, the group discussion method has a wide range of possibilities within existing services of the Health Department. Tuberculosis and cancer detection clinics,



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Chronic Pyelonephritis  
Mixed Bacterial Infections  
Soft Tissue Infections  
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which by their very nature stir up anxiety in patients, could very well use discussion methods to allay anxieties and clear up misconceptions regarding disease. Additional timely programs of accident prevention and Civil Defense might also consider group methods as an approach to their problems. Mothers in waiting rooms of child health clinics are particularly receptive to group discussions. Such naturally formed groups lend themselves to serious discussion of child development, child behavior, childhood illnesses and so on (9).

The staff of the mental health clinic has been using the group discussion method during the past year—meeting for one hour each week—with the specific purpose of getting to know each other better so as to work together more effectively as a treatment team. These weekly group discussions have been of inestimable value to the staff and to the professional growth of the individual members.

The fourth mental health principle is this: That *people can change*; they can change their attitudes, their relationships to other people, and their habit patterns. Most of the problems undertaken in the mental health clinic by the treatment team are problems in unhealthy attitudes and relationships between parents and their "problem children." By treating both parent and child, the attitudes and relationships can be changed into healthy ones. The amount of prevention in this type of treatment—otherwise known as child guidance treatment—cannot be measured directly. It is generally assumed that whenever a person changes from a state of poor mental health to a state of good mental health, he is indirectly providing against future liability to mental illness, but it has not been proven.

There is difference of opinion among public health administrators as to the advisability of including treatment in a preventive mental health program (10). In the Baltimore County Health Department we think that treatment is an integral part of prevention. Since there is far greater demand for treatment than it is possible

to provide, treatment is offered to a limited number as a clinical service which is not duplicated in private, general or psychiatric practice. The current case material is used in training psychiatrists, psychologists, social workers, and nurses in mental health principles.

In addition to treatment—which involves two staff members working simultaneously one hour a week with parent and child over a period of many weeks—an evaluation service is offered in the clinic. This service aims to delineate problems, explore possibilities for environmental changes, and facilitate mutual understanding among the various community agencies. For many cases referred to the clinic, the evaluation service is sufficient to take care of the presenting problem without going into lengthy and expensive treatment. Two case summaries of recent evaluations will serve to illustrate some of the possibilities for this type of preventive service.

CASE 1. J. B., age 8, was referred to the mental health clinic because of refusal to take any responsibility, tormenting parents and neighborhood children. The mother was seen six times by the social worker. She revealed the fact that the child had been adopted in infancy, that the mother has been anxious from the beginning and had tried extremely hard to get the child to conform to a preconceived pattern of model behavior. Both parents expressed the feeling that the adoption had placed a barrier between themselves and the child, who had never been told of the adoption. Behavior became increasingly unacceptable over the past two years. The child was seen twice each by the psychologist and the psychiatrist, and found to have slightly lower than average intelligence, was generally dependent and immature, lacked judgment in social situations, was constricted in personality, negativistic toward women and seductive toward men. In a conference, which included the principal and teachers from school, the public health nurse, and the mental health clinic staff, it was agreed that the core of the problem was the inability of the parents to discuss the adoption of the child or to have expectations for achievement within the child's capacity. The school was able to provide special reading classes for the child, and the clinic social worker talked further with the mother about revealing the adoption. The mother was then able to talk to the child without the barrier between them, and the child's behavior began to improve.

CASE 2. R. B., age 9½, in second grade public school,



was referred by the public health nurse and the teacher because of extreme nervousness, and poor muscle coordination. The mother was eager for help in handling the child, since she had no trouble with her other seven children. This particular child had been sickly since birth, a feeding problem, restless sleeper, enuretic, subject to nightmares, and slower in learning than the other children. An evaluation was done at the mental health clinic. The mother as seen by the social worker was a capable though uneducated woman who tried to bring her children up to be fairly independent. She had shielded this particular child and realized special handling was necessary. The child was found to be functioning on a defective intellectual level, was immature, dependent and inhibited. There was strong indication of probable diffuse sub-clinical brain damage which left slight residuals in diminished muscle tone and poor coordination. In the conference, which included the public health nurse, these findings were discussed and actual expectations for functioning were outlined. With specific findings as a guide and the continued support of the nurse, the mother has been able to work out ways to give the child special handling at home without increasing dependency.

In both these cases, the problem was defined and help given without long-term treatment being necessary. The capacity for change has not been fully recognized in the past. The mental health clinic evaluation service attempts to mobilize this capacity within patients and help them utilize it toward their own improvement.

#### SUMMARY

Four principles of mental health are the basis of the preventive mental health program of the Baltimore County Health Department.

1. Talking it out in time of stress.
2. Using initiative in solving problems and taking responsibility for action.

#### 3. Group participation.

#### 4. Capacity for change.

The program consists of two parts: (1) education of staff personnel in applying these principles in Health Department clinical service; and (2) mental health clinic where treatment is provided for a limited number. Evaluation service as a modification of treatment service, has added value in a preventive mental health program.

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## Scientific Papers

### BORDERLINE EPITHELIAL LESIONS OF THE RECTUM AND COLON<sup>1,2</sup>

MONTE EDWARDS, M.R.C.S. (Eng.)

Between the too-casual approach to potentially malignant benign tumors and that which stirs up much emotional reaction, there is a middle ground, acceptable equally to clinician, pathologist, and patient.

If it were possible always to determine definitely the clinical outcome of all lesions on the basis of an initial examination, however far-seeing, there would be little reason to proceed further. If you are playing the game safe, you belong to the school that treats them all radically, and the pathologist who is playing the same safe game will aid and abet you in this design. No one can say how many rectums have been sacrificed with this too-pessimistic approach.

Histologic examination is exposed to the same flaws and is subject to the same periodic revisions as clinical observation. In fact, all pathologic prognosis is predicated on information passed from the clinician to his laboratory colleague. Such and such a picture presents such and such a clinical course, *with variations*, and the variations are important.

A healthy skepticism often leads to a necessary reappraisal of pathologic prognosis, and it has become recognized that cell change alone is not sufficient to warrant a diagnosis of clinical malignant disease. Important contributions in this respect have been made over the past two decades. Broders' (1) introduction of the term

"carcinoma in situ" to describe the non-invasive stage of carcinomas of glandular and of squamous cell origin cleared the way for further study. Helwig's (2) observation on a large number of autopsies has drawn attention to the high incidence of polyps of the large intestine and stresses the role of epithelial hyperplasia as the precursor of subsequent new growth. He requires also invasiveness to be part of the picture of true malignancy.

Swinton and Warren (3) advanced three criteria for the establishment of malignant change in polyps:

1. anaplasia
2. irregularity of architecture
3. invasion

Two of the three should be present for diagnosis of malignant growth.

Klein and Scarborough (4) are content with local excision of a polyp that appears benign on frozen section examination, when subsequent permanent sections reveal a small focus of malignancy.

McLanahan, Grove, and Kieffer (5), discussing "adenoma malignum," found that definite malignancy developed only in those cases where invasion had progressed into the stalk at the time of a polyp's removal.

Binkley and others (6) are convinced that cancer arising in a simple projecting adenoma that does not yet show lymphatic infiltration of the submucosa can safely be regarded as a local problem.

It is unfortunate that lymphatic invasion is not recognizable by any practical means except

<sup>1</sup> Submitted August 19, 1954 for publication in the MARYLAND STATE MEDICAL JOURNAL.

<sup>2</sup> One of a series of papers from the Maryland Division of the American Cancer Society that will appear from time to time.

operation, and it is a known fact that even without pedicle invasion glandular metastasis has occurred and advanced to a point where clinical cure is made impossible. The rarity of such an occurrence does not, however, materially alter the general approach.

Carcinoma in situ, atypism, and, with reservation, adenocarcinoma grade I, are of this borderline status. Restriction of early malignant change to the surface of any lesion, with no invasion of stalk in a pedunculated lesion or of the base in a sessile lesion should not immediately invoke the more radical methods of cure. The entire lesion, with stalk or base, can often be removed by some endoscopic means, and the pathologist is given what he most clamors for, a total biopsy.

From the clinical standpoint, size, firmness, and mobility are attributes of the tumor which occupy an important place in the determination of the extent of treatment, and for this the experience of the observer needs to be evoked, not to replace the pathologist's opinion but to work in close cooperation with him, neither being so forthright that anything is lost in their exchange of opinion.

#### TYPES OF LESIONS AND THEIR PROBABLE TREATMENT

The benign epithelial tumors assume many varieties in size and character, from the wheat-grain elevations and pedunculated lesions, to the broad-based adenoma of great size. Even the smallest and most unimpressive manifestations of neoplasia must be considered as important forebears of increasing trouble.

##### 1. Mucosal Elevations of Less Than 0.5 cm. in Diameter

Occasionally single, these lesions are more likely to be multiple. Scattered or in clusters, they are mostly symptomless and are discovered only in the process of routine proctoscopic examination. They must always be thought of as part of an involvement extending beyond the reach of endoscopy and as being smaller mani-

festations of larger lesions at a higher level, or, since there is a time factor involved, the precursor of larger adenomas to make their appearance at a later date. With the discovery of a lesion of this size, routine barium study of the colon is indicated but most often contributes nothing.

The treatment, of course, consists in the removal of all lesions within the reach of the proctoscope, and this can be most readily accomplished by means of the monoterminal current applied with a suction electrode of either the Buie or Ault variety. For those who desire to be meticulous, it has been recommended that an initial biopsy be made of all these lesions before fulguration, but the alternative to this may be repeated proctoscopy.

##### 2. Pedunculated Adenoma

By far the largest number of these lesions are single, but it is unsafe to assume that others do not exist along with the one discovered. Although there may be no symptoms in their early stages, the two commonest manifestations of a polypoid tumor are bleeding and crampy pains in either abdomen or rectum. In fact, a polyp is the usual reason for this combination. Of course, endoscopy will discover more lesions than any other method of examination. X-ray study is by no means certain in its results but will play a major part in determining the presence of additional lesions when they are large enough or the existence of polyposis. Insistence on the part of the proctologist that the roentgenologist search further is sometimes quite productive. With or without air-contrast studies, lesions of less than 1 cm. diameter will generally escape notice.

The practice of removing small pieces of tumor from its surface for so-called biopsy purposes is to be discouraged. Complete removal of tumor and stalk, flush with the surrounding mucous membrane, is desirable in each case. With the entire lesion in his hands, the pathologist can express more than just an opinion about cell structure and can determine what may be the

subsequent course of procedure in treatment. Therefore, within reason and exposing the patient to as little danger of complications as possible, all pedunculated lesions of 2.5 cm. or less in diameter within an arbitrary 25 cm. of the anus should be removed by diathermy snare, followed by coagulation of the stump with the suction electrode. Greater difficulty will be experienced in removing these lesions by the electrode alone. For anyone who is experienced in the use of the snare, no greater danger will be involved in the more rapid method, which, incidentally, is more comfortable for the patient.

Having given the pathologist an opportunity of expressing his opinion about the lesion, and presuming that he does report invasion into the pedicle, there is pause to decide what shall be the next move. Should one assume that the malignancy has already passed beyond the confines of the initial lesion or invaded the lymphatics and spread to lymph nodes? Should one be in any hurry to perform more thorough removal of the bowel, or is one entitled to watch for clinical evidence of either invasion or ulceration?

The only serious deterrent to conservatism along these lines is in the invasion of lymph glands at perhaps a considerable distance from the primary tumor. Without performing a major procedure in every case, the extent of this spread cannot be determined. The general feeling is that one should take a calculated risk. I, for one, know that I have removed a rectum on the basis of a pathologic report, subsequent study of the tissue showing absolutely no evidence of wider spread. The conservative approach is, therefore, to be followed, for a while at any rate, for all low placed lesions. Endoscopy is repeated at monthly intervals at first, lengthened to semi-annual intervals later. This would seem to be the rational approach.

The problem of the pedunculated lesion requiring transcolic removal is not nearly so simple. If it were reasonable to do a periodic "second or third look," there would be no need for major decision on one inspection. In this respect, frozen section can be helpful in determining whether resection should be done at the first operation, but palpation may be the deciding

FIG. 1. From all appearances, a typical adenomatous polyp, removal of which would be accomplished by means of the diathermy snare through an operating proctoscope or by transcolic polypectomy if at a higher level. Surface biopsy may show some change in cell architecture suggestive of malignancy, which need not excite too great anxiety. However, in this case, invasion had already taken place into the stalk, and resection was done. A lesion of this type may have already produced involvement of lymph nodes without too much evidence of local trouble.

FIG. 2. Broad-based adenoma, sometimes called papillary adenoma, and, if its surface is shaggy, a villous tumor. Soft in consistence, with no palpable induration either on its rectal side or on palpation through the posterior wall of the vagina, the pieces represent all of the lesion, removed by means of the diathermy snare through the  $1\frac{1}{2}$  inch diameter Gorsch proctoscope, with thorough coagulation of the base. The pathologist's report introduces an element of doubt as to the exact character of the cells and the extent of invasion, but subsequent follow-up leads the clinical observer to believe that healing will be complete. Because of the position of the lesion, the only alternative would be abdomino-perineal excision, with permanent colostomy.

FIG. 3. Another broad-based adenoma with very positive malignant change, next to the anus, requiring radical treatment. The cancerous part of the lesion is by vaginal and rectal

palpation hard and inelastic, but the remainder is almost pultaceous to the feel. Had this patient been alert to her original trouble, she would not have needed an abdomino-perineal excision; performed in July, 1949, there has been no recurrence to date.

FIG. 4. Frank adenocarcinoma of polypoid type, 12 cm. from the anus, having all the appearance of a benign adenoma, but of such firm consistence and with so much induration in its base that there is clinically no mistaking its character. Surface biopsy confirms this impression. Removed by anterior resection, with low end-to-end anastomosis, in June, 1950, with no evidence of recurrence to date.

FIG. 5. Fifteen pedunculated benign lesions, from ileocecal valve to sigmoid colon, in a man fifty-two years of age, with no history of familial disease. Any one of the lesions is potentially malignant, but none had any evidence of invasion into its stalk. Colectomy with low ileosigmoidostomy was done in June, 1950. There have been no lesions in the stump, and no evidence of metastasis.

FIG. 6. The typical pseudopolypoid of ulcerative colitis, with no evidence of malignant change but having marked malignant potentiality. True adenomatosis may be an intermediate phase. One is given to wondering whether more cases of true adenoma may not have an inflammatory background; mild inflammation and epithelial hyperplasia often co-exist.



FIG. 1

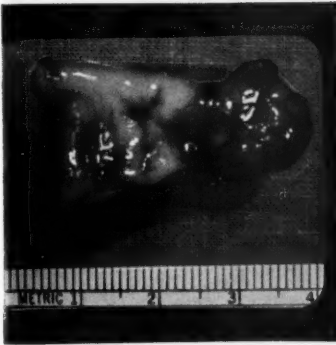


FIG. 2

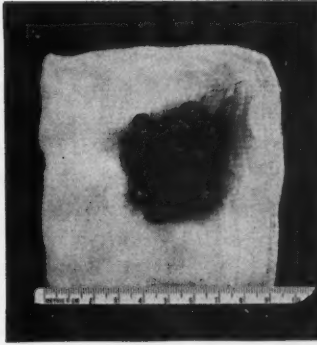


FIG. 3

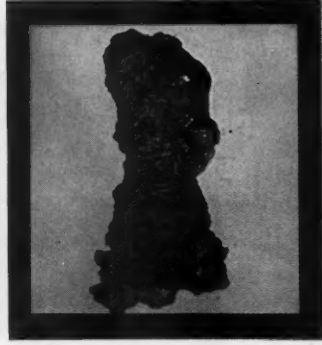


FIG. 4



FIG. 5

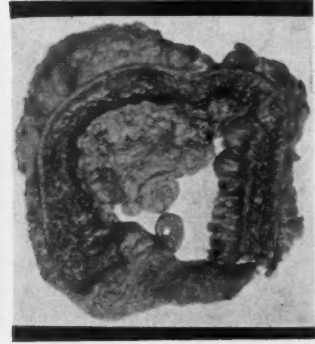


FIG. 6

factor where there is firmness and obvious spread into neighboring gut. Involvement of lymph glands will, of course, necessitate a much more comprehensive removal. Examination of the interior of the bowel through the open abdomen by means of the long endoscope, or so-called colonoscopy, has the unfortunate limitation that it can determine only what is present at the time. The process does not en-



FIG. 7. An autopsy specimen. An excellent example of villous tumor, so soft and so little removed from the normal in consistence that its presence may escape all but the trained finger, and at any level throwing no perceptible shadow in a barium enema. Surface biopsy here is useless; malignant change invariably starts in the base. Smaller lesions make excellent total biopsy.

visage multiplicity of a metachronous type. The question of how many tumors constitute polyposis and premeditates total colectomy is yet another factor to be considered. An important time-element is always involved. Why not do resection in all cases of pedunculated adenoma? Only for the reason that the difference in operative mortality is four per cent.

### 3. Broad-based Adenoma

Whether one refers to these lesions as papillary adenoma, papilloma, or villous tumor is immaterial. All are potentially malignant, and their malignancy will make itself manifest almost invariably in the base and not on the surface. From the point of view of location, few are ever

discovered beyond the sigmoid colon. The fact that they reach large size before being detected indicates that they remain symptomless for long periods. The presence of blood-tinged mucus or mucus alone in the stool may be the first manifestation, and as the lesion gradually encircles the bowel there is an increasing resistance to peristaltic activity. Obstruction never completely occurs, but impaction above a complete lesion is a quite common situation. The diagnosis is best accomplished again by endoscopy, and it is again never to be assumed that the lesion seen is the only one present. Barium enema for the discovery of other tumors is routine. As with other benign tumors, surface biopsy is not particularly helpful.

The treatment need not be quite so baffling as at first it appears to be. The principle of total biopsy fits in very well with removal of those tumors within easy reach of the large bore proctoscope and repeated application of the diathermy snare. The same principles will apply here as in dealing with pedunculated lesions. The lesion is removed, the rectum preserved.

Such measures as snare removal and coagulation have been routine over a number of years, in some cases even with the tumor above the level of the peritoneal reflection, and many such cases have shown no recurrence. The height of the lesion and its extent modify the approach but do not quite put them in the same category as malignancy, unless there is definite evidence to the contrary. An occasional case will be beset by so much technical difficulty that a combined operation with colostomy may be necessary, but not infrequently the case lends itself to the various rather tricky modifications of rectal excision which preserve normal bowel continuity. In this respect, probably the best operation for low placed benign tumor at or above the peritoneal reflection is the combined abdominosacral procedure introduced by Kraske, more recently popularized by D'Allaines (7). Two such cases of long standing in my experience, operated on in 1947 and 1948 respectively, have

made excellent recoveries, without evidence of recurrence to date.

#### 4. Benign Tumor with Obvious Malignant Change

Where a patient has permitted a benign lesion to stay undisturbed for a lengthy period, and there is no doubt about invasive cancer having been superimposed, there is, of course, only one approach. All diagnostic aids are brought into action. The most radical surgery is advised. Normal function is restored, if possible, but not at the expense of cure.

#### 5. True Adenomatosis and Pseudopolyposis

Whether familial or acquired, true adenomatosis, or whether of the false variety arising from a non-specific colitis, sometimes assuming the character of true adenomatosis at a later date, a high malignant potential is to be expected in all cases of multiple lesions. However, no one is prepared to say when, exactly, polyps are multiple. The degree of severity of symptoms may be the determining factor, but in any case colectomy should be seriously considered.

#### CONCLUSIONS

1. In dealing with all accessible benign lesions of the rectum and colon, "total biopsy" should be done wherever possible, and the removal of small pieces from the surface for pathologic examination eliminated.

2. Histologic findings and clinical observation

are both of importance in deciding the extent of subsequent treatment.

3. Endoscopic observation of a fulguration site may be the factor which determines further radical treatment.

4. All patients who have at any time had a benign tumor should be given endoscopic examination at periodic intervals.

5. In the relationship between surgeon and pathologist it is a prerequisite that each understands the other's language in determining what course may be taken after histologic study.

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#### PRESIDENT ASKS 2-YEAR DOCTOR DRAFT EXTENSION

##### The AMA Washington Letter, No. 84-3

President Eisenhower formally requested Congress on January 13 to extend the doctor draft another two years beyond July 1 as part of a 3-point military program also calling for a 4-year extension of the regular draft and creation of a new reserve program. The President declared: "In the case of doctors and dentists, I recommend that the extension be for another period of two years only. By that time, it is expected that the medical personnel requirements of the armed forces can be met adequately by other means." If Congress acts favorably on the proposal, this would mean the doctor draft would expire July 1, 1957.

**GASTROENTEROLOGY IN GENERAL PRACTICE\***

June 3, 1954

Dear Bill,

I find, after reading your most complimentary letter, that I'm still pleasantly affected by flattery. Your request for some advice from an oldster about how you may better diagnose and manage the patients with gastro-intestinal complaints who are seen in your general practice was especially gratifying, since you youngsters, speaking relatively, have always seemed to me to be so self-sufficient, well-trained, and adequate. Indeed, I've often considered you to be my severest critics. But let's consider your question!

You are fundamentally a clinician and all of us who see patients with complaints concerning organs hidden behind the abdominal wall must use the history as our first, and sometimes best, diagnostic tool. Never forget the aphorism whispered by a Continental gastroenterologist of an older generation: "Listen to the patient, Doctor; he is telling you the diagnosis!" It may be a tedious task, interpolated with much irrelevant material, but it usually supplies a key to the solution of the problem as well as the presentation of that problem. The humblest practitioner can take an excellent history and get as much from it as can the university consultant. The patient may be a poor observer and often the greatest patience on the part of the doctor is necessary to get at the facts. From a good history one can often tell whether or not it is likely that the patient has organic disease and, if he has organic disease, whether it is in the abdomen or merely a reflection of organic trouble that is located elsewhere. Perhaps there is neither organic disease nor reflex abdominal symptoms from disease elsewhere, the digestive complaints being entirely on a functional or

nervous basis. I usually allow the patient to tell his own story in his own way and, of course, he tells his presenting complaints first. I try to list the symptoms as pain, gas, heartburn, diarrhoea, distention, etc., and to analyze them as to their onset in time, their location, whether they have come in attacks and, if so, what time of day the attacks began, their relationship to the intake of food, their duration, the means of relief, and usually I ask for the patient's own opinion as to the cause of the symptoms. Sometimes it's helpful to get a story of an average day, from the medical viewpoint, when the patient's complaints are present. This gives us some knowledge of the influence of work, of rest, of food, of medicine, of posture, of bowel movements, of vomiting, and so forth.

The patient with abdominal complaints is a person as well as a belly and, in the family history, in the past medical history, and in the social history, we learn of that person and we can often obtain a very good idea of his intelligence, of his ability to withstand discomforts, and of the material of which he is made. I've never believed that lists of questions with "yes-and-no" answers give the valuable diagnostic picture that a chronologic story-history gives.

I'm sure that you know the usual syndromes of gastro-intestinal diseases and I need not recount them at length. Let me remind you to pay particular attention to dysphagia, especially when the subjective obstruction is associated with regurgitation or vomiting. And don't forget that appendicitis is essentially an acute disease with leukocytosis; lower right quadrant pain without a history of acute attacks probably isn't appendicitis. Remember that mild ulcerative colitis need not always give gross blood in the stools but it always will cause microscopic pus to appear in the faeces. The dictum about the occurrence of gall stones in the "fair, fat, and forty" multipara with upper abdominal com-

\* Submitted June 4, 1954, for publication in the MARYLAND STATE MEDICAL JOURNAL.



plaints is only a fair one; unless there is pain, expensive cholecystograms will probably show no disease. Never forget to enquire about the presence of mucus in the stools; when that occurs in quantity without association with the passage of gross blood, one can expect to find little more than an irritable (spastic) colon. I need say nothing about the need for *very serious consideration* of all gastro-intestinal tract bleeding. It may be that you and others may not be able to locate positively the source of haemoglobin leaking from the upper or lower gastro-intestinal tract; but do your very best to track it down, lest later the lesion become apparent when one can do nothing much for its cure. When you can't find a source for the bleeding, try to keep the patient under observation for several months and that may keep your serious diagnostic mistakes minimal. What about the pancreas? The diagnosis of diseases of that organ, other than diabetes, is generally difficult. The first point in the diagnosis of pancreatic neoplasm or of pancreatitis is to have these conditions in mind. The text-books tell you about suspecting pancreatic cancer when obstructive jaundice is present without much pain in the elderly. What they don't tell you is that persisting pain in the upper abdomen, especially in the upper left quadrant, in patients whom you, their doctor, know to be stable emotionally, may mean pancreatic carcinoma when other causes of that pain can be excluded. You know your patients and you are a better judge of the amount of pain that they are having than is a consultant.

Examine your patients! You have the precious opportunity of seeing them when they are having symptoms, something which the consultant can only hear about, as a rule. And nothing re-enforces or contradicts a history more than the findings when a patient has an acute attack.

Inspect the whole patient. Never forget to make a clinical estimate of his haemoglobin from

the colour of his palms, of his nail beds, of his ears, or of his mucous membranes. And always look for jaundice which others haven't picked up. Spider angiomas will occasionally call your attention to hepatic disease and varices on the abdomen are important. I've failed to find inspection of the tongue to be very helpful in the diagnosis of gastro-intestinal disease unless it is quite atrophic or very red. Look at it, of course, when you suspect deficiency syndromes; pellagra still occurs, though 'tis uncommon in my experience. Note the dental situation chiefly for the patient's ability to masticate his food. To be sure, dental deficiencies rarely produce digestive symptoms, but, nevertheless, pay some attention to the grinding surfaces.

Abdominal palpation may or may not be rewarding to the medical detective. Yet I've recently read that Dr. Hangar, who first described the cephalin flocculation test, has written, "One good feel of the liver is worth any



"But what ever possessed you to become a gastro-enterologist?"

Reproduced by permission. Copr. 1954  
The New Yorker Magazine, Inc.

two tests of hepatic function." Go over the abdomen gently before you bear down; occasionally something will be ballotable and you'll be able to learn whether or not the patient is hyperaesthetic. Then go after tenderness and attempt to palpate the solid organs and masses. Don't forget that a spastic colon, even in its transverse portion, is frequently palpable. I can't recall when I've palpated a patient's abdomen when he was in a hot tub. But it's an excellent method and 'tis probably too seldom employed. When a patient is vomiting after an operation, a succussion splash (clapotage) is a sign that gastric aspiration is in order.

Percussion of the abdomen is a bit old fashioned and, except in suspected ascites, I learn little from it.

I find that the younger men are more inclined to listen to the abdominal sounds with a stethoscope than I am. I've rarely found that to be very helpful, though I'm tolerant of the use of the auscultatory method.

What can I tell you about the examinations of the rectum and of the female pelvis that you don't know? Certainly inspection of the anus and digital rectal examination are always in order in these cancer-conscious times; probably most of your adult clients will appreciate such an examination because they have read in publications about cancer that "good doctors" make digital rectal examinations. Your clinical judgment will tell you when to make a vaginal examination. I'm likely to examine a woman's pelvis when the nature of her abdominal complaints is at all obscure, or when symptoms referable to her reproductive apparatus are present.

Since my practice is chiefly a gastroenterologic one, I make proctoscopic examinations almost routinely; I suppose that I do that chiefly because it's expected of me. Certainly I don't expect you to look into the rectum of everyone who comes to you with a sore throat. But you'll want to inspect the rectum occasion-

ally and there's no reason why you shouldn't do so. You look into the mouth and throat and you can look into the rectum with only a little more trouble. I use a proximally lighted Kelly-type of proctoscope. It is eight inches in length and its half-inch calibre makes it well tolerated by tense patients. A Buie table for proctoscopy is sometimes desirable but it's certainly not necessary and I usually have my patients assume the knee-chest position for the procedure. We are fortunate in having Mother Nature locate a very high percentage of tumours in the lowermost part of the bowel where they can be palpated or inspected. And most ulcerative colitis of the non-specific type begins in the rectum where we can see the mucosal changes.

It is by a multiplicity of laboratory examinations that the consulting gastroenterologist impresses his patients and it is by the judicious selection of these tests that the busy practitioner saves time and money and confirms his clinical diagnosis. Indeed, it is a rather good rule to run only those tests which will confirm clinical diagnoses, unless the gastro-intestinal problem is an obscure one. I have no set routine in the laboratory.

One of the simplest and most important tests in studying gastro-intestinal disease is the examination of the stool. I wonder whether the stoutish lady in the enclosed cartoon from "The New Yorker" was thinking of such studies when she said to the doctor, "But *whatever* possessed you to become a gastroenterologist?" And I imagine that the startled doctor is a bit uncertain about his reasons for becoming interested in gastro-intestinal disease. I hope that he will tell his questioner that the frequency with which gastro-intestinal complaints are encountered in practice made him want to know them better so that he could be of more use to his clients. In telling you about the need for faecal examinations, I'm not trying to make you a laboratorian. But I do hope that you'll inspect the faeces grossly and test them for the presence

of occult blood. I know that you aren't a parasitologist; but, if a patient brings in a pinworm or a tapeworm or a round worm, look at it! And look at a liquid stool microscopically without centrifugalization if you suspect pus to be present; it's no more difficult than the examination of the urinary sediment.

I use the benzidine test for occult blood in the faeces and I consider it to be a most useful procedure. A negative test practically excludes gross ulceration along the gastro-intestinal tube between the mouth and the anus. I place a bit of stool the size of a pea on an ordinary glass slide. On this is poured and mixed a solution of benzidine base in glacial acetic acid. Then a few drops of hydrogen peroxide are added and the resulting colour formation or absence of change is noted for about thirty seconds. If the green or blue comes out immediately and is very intense, it is called a four plus reaction; if it is very strong but is delayed a few seconds in its appearance it is called a three plus; if it is of moderate intensity and comes out rather slowly, it is a two plus reaction; still weaker reactions are termed one plus, trace, and slight trace. Positive tests are significant *only* if bleeding gums, nose bleeds, and haemorrhoidal oozing can be ruled out and if the patient has been on a meat-free, broth-free, and meat-gravy-free diet for four days prior to the passage of the specimen. Haemorrhoidal bleeding can be excluded fairly well by obtaining a bit of stool through the proctoscope from above the pile-bearing area.

Whether you determine the presence and concentration of hydrochloric acid in patients' stomachs is, generally speaking, not too important in cases of gastro-intestinal complaints. The stomach tube isn't used now as it was forty years ago and it's rarely needed. Examine the gastric content if you wish but be careful that you don't explain gastric symptoms on the results of gastric gavage alone; that's an unwise procedure, generally speaking.

You wrote that you have a small roentgen

ray unit and that you use it for making films of the chest and for fractures; that's as it should be. But I'm glad that you didn't say that you are diagnosing ulcers and tumours and gall stones with it. Though the roentgenologic examination of the gastro-intestinal tube and of the gall-bladder is simple in principle, training and experience with the method are essential. In roentgenology one is working indeed "in the shadows" and a little special training, which you may get if you wish, is most desirable. Have you not noticed that in large hospitals the skiagrams of the chest and of fractures are often read by the associates while the gastro-intestinal films are read by the chief roentgenologist?

Reserve x-ray examinations of the oesophagus, stomach, duodenum, and colon, for patients who have had unexplained bleeding from their gastro-intestinal tubes, for those with dysphagia, for those with chronic dyspepsia, for elderly patients with relatively short histories of abdominal symptoms or a recent change in their bowel habits, and for those patients with obscure anaemias. A persistently positive benzidine test on the stool *when the diet is controlled* may be an indication for a roentgen study, especially if abdominal symptoms are present. Every belching woman isn't a candidate for cholecystograms, but upper abdominal dyspepsia with pain which doesn't respond to antacids and to antispasmodics and to diet may make such a roentgen study necessary. The syndrome of a thoracic stomach deserves roentgen investigation, I think. And you'll feel better about people who vomit a good deal if you have roentgen studies made of their stomachs before you have followed them for too long a time.

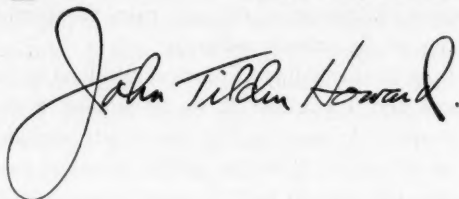
My remarks here have concerned gastroenterological diagnoses chiefly rather than treatment. And I've limited the laboratory studies to those which you can make; you'll know when tests of hepatic function, of the pancreatic ferments in the blood and in the duodenal juice, etc., are needed. Oesophagoscopy and gastro-

scopic examinations are certainly out of your field; I doubt that you care to make these studies anyway, since you have so much other work. With your simple tools make a working diagnosis first. The text-books will give you the treatment. Then, when your patients fail to do well and when you have convinced yourself that they have something really wrong, don't hesitate to ask your colleagues for assistance. The patient will appreciate your solicitude for him and you'll sleep better for having had your opinion confirmed—as it will be in most cases—or in having an obscure problem solved to your edification.

I hear "through the grapevine" that your

patients are devoted to you and that you are going day and night. That's as it should be but don't go so hard that you are too tired to think a little; so often we are too busy to think!

Yours always sincerely,



John Tilden Howard  
12 East Eager Street  
Baltimore 2, Maryland

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#### RESOLUTIONS FOR PRESENTATION TO THE HOUSE OF DELEGATES

APRIL, 1955

*The Council of the Medical and Chirurgical Faculty has ruled that resolutions must be in the Faculty office by March first if they are to be considered at the Annual Meeting. However, the Council reserves the right to review and forward, if it thinks desirable, any resolution received at a later date.*

*If the component societies and their members comply with this recommendation the Secretary will then be able to send copies of the resolutions that are to be presented to the House of Delegates to each component Medical Society and delegates in time for the proposals to be discussed among the members. The component society may therefore instruct its delegates so that they in turn may cast their votes as representative of the component members' desire.*

*If you or your component Medical Society wish to submit a resolution to the House of Delegates at the meeting on April 21, 22, and 23, 1955, please send it to the Secretary of the Faculty, Dr. Everett S. Diggs, 1211 Cathedral Street, Baltimore 1, Maryland, by Tuesday, March 1, 1955, or as soon thereafter as possible.*

#### PHYSICIANS THROUGH 37 BEING EXAMINED FOR DOCTOR DRAFT

The AMA Washington Letter, No. 102

To meet the Defense Department call for 1,275 physicians for induction next March, draft boards have started processing men through the age of 37. Selective Service headquarters instructed boards to call up for examination those priority 3 physicians born on or after January 1, 1917, where previously the cutoff birth date was August 30, 1922. To meet Defense quota of 459 dentists in March, priority 3 registrants born on or after January 1, 1910, are being examined. In the case of both physicians and dentists, priority 1 of all ages and priority 2 men without restriction as to months of service also are being used for the March call.



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## ARTICLES OF INTEREST

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### NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

120 Broadway, New York 5, New York

#### *Summary of National Planning Meeting on*

#### *1955 Poliomyelitis Vaccine Program*

January 10, 1955

On invitation of the National Foundation for Infantile Paralysis, official representatives of the American Medical Association, the American Academy of Pediatrics, the Association of State and Territorial Health Officers, the American Public Health Association and the U. S. Department of Health, Education and Welfare met in New York on January 10. The purpose of this meeting was to consider nationwide administrative policies relative to the distribution and administration of the supply of poliomyelitis vaccine being purchased by the National Foundation for Infantile Paralysis for possible rapid application in the prevention of poliomyelitis in the spring of 1955. The deliberations of this group were predicated on the assumption that the evaluation of the 1954 poliomyelitis vaccine field trial now being conducted by Dr. Thomas Francis, Jr. at the University of Michigan would justify the licensure of this product by the National Institutes of Health, U. S. Public Health Service. Dr. Francis' report is expected to be issued about April 1, 1955.

The consensus of the meeting was as follows:

1. That if and when licensed by the National Institutes of Health, the vaccine will be supplied by the National Foundation to state health officers in amounts sufficient to provide for the vaccination of

a. Children who participated in the vaccine field trial in 217 field trial areas in the United States in 1954, but who did not receive vaccine at that time.

b. All children enrolled in the first and second primary grades of all public, private and parochial schools in the continental United States, Alaska and Hawaii in the spring term of 1955.

2. The plan of administration of the vaccine in any

state or territory will be the administrative responsibility of the respective state or territorial health officer and will be worked out by him in cooperation with the state or territorial medical society and state or territorial education officials.

3. The 1955 vaccine program has been initiated by the National Foundation for the purpose of making possible early and widespread application of a newly established preventive measure against paralytic poliomyelitis; after completion of this program, the National Foundation will not participate in the production, distribution or administration of poliomyelitis vaccine.

4. The children in the first and second grade of primary schools were selected for the program because of high incidence of paralytic poliomyelitis in this group and their accessibility as organized units within the schools, keeping in mind the limitations on the amount of vaccine to be available for this program.

5. It is expected that additional vaccine, equivalent or greater in amount than that contracted for by the National Foundation, will be obtainable through usual commercial channels for the use of private physicians for their patients.

6. Vaccine for use in 1955 will be administered on the same dosage schedule as was followed in the 1954 field trial, namely 1 cc. of vaccine in each of the three doses, given intramuscularly, the second inoculation one week after the first and the third inoculation four weeks after the second.

7. Administrative procedures for the giving of the vaccine will be as simple as possible and will not require extensive record-keeping. Except in those states which wish and are in a position to conduct follow-up studies, no extensive nationwide evaluation such as was done in the 1954 field trial is contemplated.

8. Upon request from state health officers, the National Foundation will supply educational and other printed materials for use in the conduct of the vaccination program and will provide local cooperation and assistance through its Chapters in all counties, as requested by local health authorities.

The official organizational representatives attending this meeting were the following:

*American Medical Association*

Dr. Thomas Murdock

Dr. Julian Price

*American Academy of Pediatrics*

Dr. Harry Bakwin

Dr. Aims McGuinness

*Association of State and Territorial Health Officers*

Dr. D. G. Gill

Dr. Franklin D. Yoder

*American Public Health Association*

Dr. Herman E. Hilleboe

Dr. Reginald M. Atwater

Dr. Granville W. Larimore

*U. S. Department of Health, Education and Welfare*

Mr. Simon A. McNeely

Dr. Katherine Bain

Dr. Leroy E. Burney

Dr. Roderick Murray

*National Foundation for Infantile Paralysis*

Dr. Hart E. Van Riper

Dr. G. Foard McGinnes

Dr. Thomas D. Dublin

## THE DISABILITY PROVISION OF THE FEDERAL OLD-AGE AND SURVIVORS INSURANCE PROGRAM

MAURICE D. DEWBERRY\*

One of the recent amendments to the Social Security Act preserves the old-age and survivors insurance rights of individuals who have been totally disabled for an extended period before attaining age 65. Maryland physicians will find information about the new provision useful in their practice because disabled patients may request help in establishing eligibility for the "freeze."

Increasing efforts are being made to restore more of our disabled persons to gainful activity. In 1954 Congress improved and expanded the scope of the Vocational Rehabilitation Act, and made available additional funds under the Hill-Burton Act for the construction of rehabilitation facilities. The "disability freeze" amendment to the old-age and survivors insurance provisions of the Social Security Act

will serve also to stimulate vocational rehabilitation activities throughout the nation. The Bureau of Old-Age and Survivors Insurance, a part of the Social Security Administration in the Department of Health, Education, and Welfare, has responsibility for the operation of the Federal old-age and survivors insurance program. The officials of this Bureau have asked the Nation's medical profession for cooperation and counsel in the formulation of sound standards and the application of them in making determinations of disability for purposes of this program.

Under the Old-Age and Survivors Insurance program, wage earners, their employers, and self-employed persons contribute to a fund from which wage earners and self-employed persons may be paid monthly old-age insurance benefits upon retirement after age 65, and, from which their survivors may be paid monthly benefits.

The "disability freeze" provisions bears some resemblance to the waiver-of-premium clause in commercial life insurance policies. It does not provide cash benefits during a period of disability; it simply enables an individual to preserve his rights to old-age and survivors insurance benefits during a period when he is unable to work because of total disability which has existed for some time and is expected to be of prolonged duration. It provides for the use of the skills of professional persons in State and local agencies to get the facts about an applicant's physical or mental impairment. It also directs the Department of Health, Education, and Welfare to refer the disabled applicant to a State agency for possible vocational rehabilitation services.

For a person to become entitled to old-age insurance benefits, or for his family to become entitled to survivors' benefits in case of his death, he must have engaged in work covered by the program for a specified length of time. The amount of monthly benefits is based upon his "average monthly earnings" in such work. Before the enactment of the disability freeze, periods of low or no earnings, such as those caused by disability, reduced his average monthly wage and resulted in lesser monthly benefit amounts. It was even possible to lose eligibility to benefits because of prolonged absence from covered work. The new provision preserves a disabled person's right to full benefits by allowing the exclusion of a period of extended disability in the computation of his benefit amount.

\* Regional Representative, Bureau of Old-Age and Survivors Insurance, Social Security Administration, Region III, Washington, D. C.

The term "disability" is statutorily defined as: "...inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration, or blindness."

The only impairment which is specifically defined is "blindness." It is defined as central visual acuity of 5/200 or less in the better eye with the use of a correcting lens. An eye in which the visual field is reduced to 5° or less concentric contraction is considered as having a central visual acuity of 5/200 or less. (An individual with a visual impairment which does not meet this definition may, however, be considered and may be found eligible under the general definition.) A person whose sight is impaired to the extent defined in the law is deemed blind regardless of whether he is able to engage in gainful activity. The determination of whether an individual's impairment may be deemed to be a "disability" must be made upon consideration of the medical evidence and by application of medically approved standards of disability.

In general, determinations of disability will be made by a State vocational rehabilitation or other appropriate State agency, under an agreement entered into with the Secretary of Health, Education, and Welfare. The State agency will be reimbursed for the necessary costs of making such determinations.

A large number of freeze applications are expected in the early months of 1955 because persons with sufficient covered earnings who are currently disabled may establish periods of disability retroactively to the earliest date they were disabled and could meet the covered work requirements for a period of disability.

The Bureau has enlisted the counsel of a Medical Advisory Committee whose members will be representative of the various fields of the medical profession. This committee will assist in the development of policies, standards, and procedures for the procurement and evaluation of medical evidence in accordance with sound medical practice.

In formulating standards and guides for the evaluation of disability, the Bureau of Old-Age and Survivors Insurance and the Medical Advisory Com-

mittee will have the benefit of experience acquired by professional personnel in the administration of Federal and State disability programs such as vocational rehabilitation, the veterans' programs, workmen's compensation, aid to the permanently and totally disabled, and other disability retirement programs.

The medical aspects of a disability determination will be based upon medical evidence furnished from either of two sources:

1. The person may ask his physician to send an abstract concerning his impairment to the office handling the person's application for a disability determination. A brief form which has been prepared for this purpose will provide space for medical history, clinical findings, and diagnosis of the impairment. In some cases, it may be necessary for the disabled person to have a current medical examination in order to meet the requirement that he furnish medical evidence to support his application; or

2. The disabled person may arrange to have submitted in his behalf a summary of an existing medical record in a hospital or other institution or agency.

If the medical evidence submitted by the applicant is not acceptable or is inconclusive, a current medical examination may be authorized. Arrangements for such examinations will ordinarily be made by the State agency with a local physician, as is now done when the agency secures an examination for its own purposes. Payment for such examinations will be made by the State agency which, in turn, will be reimbursed by the Bureau of Old-Age and Survivors Insurance.

To qualify for a disability determination, a person must have worked in employment covered by the Social Security Act for a substantial period prior to the onset of his impairment. Briefly, he must be credited with earnings for at least 5 years out of the last 10 years, including at least 1½ years out of the last 3 years immediately before the onset of his disability.

A person's earnings record cannot be frozen until he has been disabled for 6 months and it appears that he will suffer prolonged disability or death. In addition, he must be still disabled when he files his application for the disability determination. A period of disability ends when the disability ceases or he attains age 65.

A person who files an application before July 1, 1957, for a "freeze" may establish a period of dis-

ability which extends retroactively to the time when he could have first met the eligibility requirements. A person who is now receiving old-age insurance benefits and who was totally disabled before age 65 may have the amount of his monthly benefits increased by filing a valid application for a "freeze." However, no benefit amounts can be increased for months before July 1955, and the applicant must be living on July 1, 1955, for his application to be valid.

An application to establish a period of disability for Old-Age and Survivors Insurance purposes should be filed by the worker in the nearest social security district office. There are six district offices serving residents in Maryland. Two of these are located in Baltimore—in the Post Office Building and at 3107

Greenmount Avenue; the other offices are located in Cumberland, Hagerstown, Salisbury and Washington. Itinerant service in other communities is provided by each of these offices, and a representative will call on persons who may be confined to their homes. Additional information concerning the disability "freeze" program can be obtained from any of the above district offices.

*Department of Health,  
Education, and Welfare*

*Social Security Administration*

*Region III*

*Washington, D. C.*

#### ANNUAL MEETING—EXHIBITS

April 21, 22, 23, 1955

The Exhibitors make our Annual Meeting possible, so please be sure to visit the exhibits. You will find representatives from the following pharmaceutical companies, publishers, etc., in attendance: A. S. Aloe Company; Ayerst, McKenna & Harrison Ltd.; Baby Development Clinic; Brayten Pharmaceutical Company; A. J. Buck & Son; Ciba Pharmaceutical Products, Inc.; Coca-Cola Bottling Company of Baltimore; Herbert Cox—Correct Shoes; Desitin Chemical Company; Doho Chemical Corporation; C. B. Fleet Company, Inc.; Graymar Company; Hynson, Westcott & Dunning, Inc.; Kroman Instrument Company, Inc.; Liebel-Flarsheim Company; Eli Lilly & Company; Mead Johnson & Company; Murray-Baumgartner Surgical Instrument Company, Inc.; Ortho Pharmaceutical Corporation; Pfizer Laboratories, Inc.; William P. Poythress & Company, Inc.; Riker Laboratories, Inc.; A. H. Robins Company, Inc.; J. B. Roerig and Company; W. B. Saunders Company; G. D. Searle & Company; Seven-Up Bottling Company of Baltimore; Similac Division of M & R Laboratories; Raymond K. Tongue Company, Inc.; The Upjohn Company; U. S. Vitamin Corporation; Walker Laboratories, Inc.; and The Williams & Wilkins Company.



## Component Medical Societies

### ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

*Journal Representative*

The October 9, 1954 meeting of the Allegany-Garrett County Medical Society was held at the Memorial Hospital Nurse's Home, in Cumberland. The principal speaker for the evening was, Dr. Charles H. Wainwright. His subject was "Arthritis and Related Diseases—Diagnosis and Treatment."

The Society held its last meeting of the year on December 2nd in the Grand Ball Room of the Fort Cumberland Hotel. The photograph shows the doctors and their wives enjoying the banquet. This was the first meeting the wives have attended in thirty-four years.

#### DR. STEGMAIER ADDRESSES PUBLIC MEETING

Dr. James G. Stegmaier gave an address titled, "Self Detection of Cancer" in an open meeting to the public, on January 18th, in the Knights of Columbus Hall, Cumberland, Maryland.

Dr. Stegmaier graduated at the University of



DR. FRANK T. HARRAT, *President*, Allegany-Garrett County Medical Society; DR. CHARLES H. WAINWRIGHT, *Speaker*; DR. LELAND B. RANSOM, *Secretary*, Allegany-Garrett County Medical Society.



DR. JAMES T. JOHNSON, JR.; DR. F. T. HARRAT, *President*, Allegany-Garrett County Medical Society; MRS. HARRAT; DR. WILLIAM S. LOVE; DR. MURRAY McCASLIN, *Speakers*; MRS. RANSOM, DR. LELAND RANSOM, *Secretary*, Allegany-Garrett County Medical Society.

Maryland, in 1942 and did his residency in surgery at Mercy Hospital. He is a member of the American College of Surgeons and specializes in surgery. He is married to the former Nellie McCrorie, of Cumberland. His hobby is boating on Deep Creek Lake.

#### HAPPENINGS OF YESTERYEAR

*November 1, 1908*

Home and Infirmary of Western Maryland, later renamed Western Maryland Hospital, in Cumberland, is no more; having since become Memorial Hospital in 1928.

Only six physicians live to read their names in happenings of forty-seven years ago.

Drs. V. H. Deming, Charlotte B. Gardner, J. Kile Cowherd and F. A. G. Murray are still in active practice in Cumberland. Dr. Charles L. Owens is retired from practice, but much alert to goings on of today.

Five of the physicians have left sons to carry on in active practice, in Cumberland, as of today.

Roster of the above date follows:

*Surgical Staff*—Drs. Arthur H. Hawkins, James T. Johnson, Sr., Thomas B. McDonald, A. Leo Franklin.

*Assistant Surgeons*—Drs. Willis R. Hodges, William W. Wiley, Frederick W. Fochtman, Charles L. Owens, Henry S. Wailes, and H. V. Deming.

*Medical Staff*—Drs. Edward H. White, Edward T. Duke, Thomas W. Koon and William F. Twigg.

*Specialists*—Drs. Emmett L. Jones, Sr., E.E.N.T., Robert Y. Fechtig, E.E.N.T., Charles H. Brace, Homeopathist, Catherine Buell, Female physician, Henry W. Hodgson, neurologist, Charlotte B. Gardner, pathologist.

*Consulting Surgeons*—Drs. James M. Spear, Cumberland, J. M. Price and T. M. DeNaouley, Frostburg, F. A. G. Murray, Mt. Savage, James Carpenter, Midland, W. Q. Skilling, Lonaconing, D. F. Dunott, Chief Surgeon Western Maryland Railroad, Drs. A. C. Harrison, Sinclair Sponill and Page Edmonson, surgical staff, Baltimore and Ohio Railroad.

*Consulting Physicians*—Drs. J. J. Jones Wilson, Cumberland, Drs. Timothy Griffith, J. C. Cobey and W. O. McLane, Sr., Frostburg; Drs. A. G. Smith and E. P. O'Neill, Midland; Drs. J. O. Bullock and W. H. Hodgson, Lonaconing; Dr. F. L.

Clymer, Midlothian; Dr. C. J. Fazenbaker, Westernport; Dr. J. K. Cowherd, Mt. Savage, and Dr. A. P. Twigg, Flintstone.

### BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

*Journal Representative*

Dr. Amos R. Koontz, the President, has appointed the following Committees for 1955:

#### CONSTITUTION AND BY-LAWS:

Moses Paulson, *Chairman*, Marius P. Johnson, Lawrence R. Wharton.

#### COMMITTEE TO ADVISE THE DIRECTOR OF THE BALTIMORE CITY CIVIL DEFENSE HEALTH SERVICE:

John Sheldon Eastland, *Chairman*, Whitmer B. Firor.

#### COMMITTEE ON EMERGENCY MEDICAL CALLS:

Louis F. Klimes, *Chairman*, Louis Z. Dalmau, Marion Friedman, Clewell Howell, Kenneth Krulevitz, Nathan Racusin, C. Arthur Rossberg.

#### LEGISLATIVE COMMITTEE:

Charles R. Goldsborough, *Chairman*, Louis Krause, Karl F. Mech, Daniel J. Pessagno, Richard T. Shackelford.

#### PARKING COMMITTEE:

James C. Owings, *Chairman*, Erwin E. Mayer.

#### MEMBERSHIP COMMITTEE:

William L. Garlick, *Chairman*, Philibert Artigiani, Dudley C. Babb, Daniel E. Bogorad, Katherine H. Borkovich, Harry C. Bowie, Thomas S. Bowyer, Charles B. Brack, Charles E. Carr, Jr., Dwight M. Currie, Joseph D'Antonio, Francis G. Dickey, Israel J. Feinglos, Samuel L. Fox, Haswell D. Franklin, Mark E. Gann, Samuel S. Glick, S. Butler Grimes, Rachel K. Gundry, Richard B. Hanchett, I. Bradshaw Higgins, Robert W. Johnson, III, George A. Knipp, Milton C. Lang, M. B. Levin, George D. Lippy, Louis R. Maser, Jacob M. Miller, William F. Pearce, William F. Renner, F. Fred Ruzicka, Lawrence M. Serra, John M. Scott, Solomon Sherman, Lawrence J. Shimanek, Henry F. Ulrich, Harry Wasserman.

#### PUBLICITY COMMITTEE:

George A. Bawden, *Chairman*, Morgan LeRoy Lumpkin, Charles Wilbur Stewart.

#### POSTGRADUATE COMMITTEE:

Samuel Whitehouse, *Chairman*, Harry M. Robinson, Jr., Samuel P. Asper, Jr., Howard M. Bubert, M. Paul Byerly, Wetherbee Fort, William G. Helfrich.

## PUBLIC MEDICAL EDUCATION:

H. Hanford Hopkins, *Chairman*, Houston S. Everett, Ernest C. Brown, Jr., Palmer H. Fletcher, Harry F. Klinefelter, Jr.

The remaining Committee appointments will run in the April issue.

The President, Dr. Amos Koontz, assumed the responsibilities of his office promptly. On Tuesday, January 4, 1955, a meeting of the Executive Board considered many problems that had accumulated since November. Sentiment against socialistic trends in government was promptly expressed concerning the Reinsurance Program and the Social Security Amendment.

Eviction of Doctors from St. Paul Street was reported as necessarily proceeding according to law. An ordinance covering this problem is in preparation for presentation to City Council.

The time of the monthly scientific meetings had been challenged and the postcard referendum was reported. Six hundred and fifty replied. Four hundred and eighteen preferred 8:30 P.M.; one hundred and forty-two wanted 9:00 P.M.; sixty-four were for 9:30 P.M.; fifteen wanted it at 8:00 or earlier, and to eleven it did not make any difference between the times suggested.

The January 7 meeting featured a symposium on inguinal hernia. Drs. Barry J. Anson and Leo Zimmerman from Chicago, authors of a recent book on hernia, were paired on a panel with Drs. Harvey B. Stone and Whettherbee Fort of Baltimore. Dr. Anson, professor of anatomy, outlined new and different anatomical concepts of herniogenesis. Dr. Fort discussed the patient's problems in accepting the diagnosis, and the clinical aspects of having a hernia, known and unknown, early and late. Dr. Zimmerman then declared for greater functional considerations in effecting the repair, and held that the old, classical imbrication concept was not physiological. Dr. Stone was moderator and outlined the problem, with some development of our ideas of treatment. There was a very active question-and-answer period, during which Dr. Zimmerman called on President Koontz for his comments, this being a favorite field of his.

The Woman's Auxiliary was on hand with coffee and doughnuts after the meeting and there was a pleasant social time.

## MONTGOMERY COUNTY MEDICAL SOCIETY

MAYNARD I. COHEN, M.D.

*Journal Representative*

The January meeting of the Montgomery County Medical Society was held at Olney Inn, Olney, Maryland, January 18, 1955. Dr. Frank Finnerty, Jr., who has conducted research at the Georgetown and D. C. General Hospitals, spoke on "Hypertension in Pregnancy." He was joined in a panel discussion by Dr. James G. Sites, Chief Medical Officer in Obstetrics, D. C. General Hospital, and Dr. Michael L. Buckley, Bethesda, Maryland.

Dr. William J. Peebles has been named Montgomery County Health Officer, effective February 1, to replace Dr. Ellicott. Dr. Peebles has most recently served as the Assistant Health Officer in Muscogee County, Georgia. He is 35, the father of three children, and was formerly a captain in the U. S. Army.

At the request of the Board of Censors of the Medical Society and in response to some recent questions, the following information regarding the size of physicians' signs and announcements of entry into practice was made available. The regulations of the Maryland Board of Medical Examiners provide that professional signs (containing the physician's name) shall not contain letters larger than three inches square nor shall announcement cards be mailed to the general public.

The following members of the Society have resigned: Doctors Edw. Steiglitz, John Lynch, Lewis Moody, and Bertram Gau.

The following are new members of the Society:

*Active*

Dr. Edmund L. Burnett  
Dr. Eino Magi

*Affiliate*

Dr. Frank Grabill  
Dr. J. R. Thistlethwaite

*Associate*

Dr. Carl N. Nelson, Jr.

Dr. Robert Hare, new President of the Society, issued the following message: "I wish to welcome new members to the Montgomery County Medical Society and express my desire to work closely with old members. Will any member who wishes to serve on one of the Society's committees so indicate either to me or to any of the Committee chairmen for 1955 listed below, so that committee assignments can be made soon."

*Committee and Chairman*

Public Relations: Dr. Charles Warfield  
 Public Health and Legislation: Dr. Allen O'Neill  
 Medical Relations: Dr. Aaron Traum  
 Civil Defense: Dr. Manning Alden  
 Alcoholic Clinic: Dr. Aaron Traum  
 Mental Hygiene: Dr. Henry Laughlin  
 Diabetes Detection: Dr. George Sharpe  
 Cancer: Dr. John Robben  
 Program: Dr. Maynard Cohen

#### DOCTOR'S DAY 1955

Again this year on March the 30th the nation will observe "Doctor's Day." The Woman's Auxiliary celebrated the occasion by presenting red carnations, the official flower, to each member of the Baltimore City Medical Society attending the regular meeting on March 4, 1955 at 8:30 p.m. Governor McKeldin will officially make a proclamation prior to this date. Last year was the first time that Baltimore City had occasion to pay tribute to its Doctors.

Originally Mrs. G. B. Almond introduced the idea to the Barrow County, Georgia, Woman's Auxiliary in 1933. The Woman's Auxiliary to the American Medical Association adopted it in 1934, and the Woman's Auxiliary to the Southern Medical Association joined in tribute in 1935. The initial resolution read, "Be it Resolved by the Auxiliary to the Barrow County Medical Society, that March 30th, the day that famous Georgian, Dr. Crawford Long, first used ether anesthesia in surgery, be adopted as Doctor's Day, the object to be the well being and honor of the profession, its observance demanding some act of kindness, gift or tribute in remembrance of the Doctors.

#### PAY RAISE ASKED FOR VA MEDICAL PERSONNEL

Employees in the Veterans Administration's Department of Medicine and Surgery will receive a pay raise if Congress supports the recommendations made by President Eisenhower in a special message urging legislation to improve certain aspects of federal personnel management. More than 23,000 professional employees in the department who are subject to Public Law 293, 79th Congress, would be affected. Included in this total are 7,800 physicians, 896 dentists, 14,833 nurses and 219 nurse-anesthetists. The raise probably would be the general 5% increase requested in the same message by the President for other federal civilian employees.



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# Necrology

A. S. CHALFANT, M.D., *Chairman*

Memoir Committee

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**Harry C. Grant, Sr., M.D.**

**1884-1954**

Dr. Grant was born in Wilmington, North Carolina, May 14, 1884; University of Maryland School of Medicine, 1914; member of the Baltimore City Medical Society and the Medical and Chirurgical Faculty of the State of Maryland intermittently between 1920-1948; non-resident member of the above associations from 1949 until his death October 30, 1954 in Houston, Texas.

**Elmer C. Hazard, M.D.**

**1879-1954**

Dr. Hazard was born in New York City, December 17, 1879; Maryland Medical College, 1904; member of the Baltimore City Medical Society and the Medical and Chirurgical Faculty of the State of Maryland from 1920-1927; non-resident member of the above associations from 1928 until his death November 6, 1954 in Long Branch, New Jersey.

## VA SEES LESS NON-SERVICE MEDICAL CARE AS RESULT OF ORDER

The AMA Washington Letter, No. 84-2

President Eisenhower's proclamation setting January 31, 1955, as the end of the period of eligibility for certain veterans' benefits is expected to cut down on non-service-connected medical care, according to the Veterans Administration, but no estimate has been made of the projected dollar savings. VA makes these points in explaining the order, issued December 31:

1. Men and women entering service after January 31 will be entitled to VA hospitalization or domiciliary care only if they are discharged for disabilities incurred in service or if they are receiving VA compensation for service-connected disabilities. To be entitled to domiciliary care, they must be incapacitated from earning a living and have no adequate means of support.

2. To establish eligibility for outpatient medical and dental care, this same group of veterans must be discharged for service-connected disabilities or be receiving VA compensation, provided they meet all other specified eligibility requirements.

3. Persons seriously disabled in service on or before January 31 will be eligible for vocational rehabilitation through the VA but those so disabled after that date will not be eligible. The end of the entire program will be January 31, 1964, or nine years after discharge, whichever is earlier.

Rep. Edith Nourse Rogers (R., Mass.) has introduced a bill that would restore benefits for all veterans, thus nullifying the President's order. Rep. Olin Teague (D., Tex.), who succeeds Mrs. Rogers as chairman of the House Veterans Affairs Committee, sponsored a bill to restore only veterans' educational benefits but not medical care privileges.



## Library



"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

### ALLERGY

LOUIS KRAUSE, M.D.\*

Undoubtedly this condition has been present as long as man has been a specific being. Probably the earliest literary reference to an individual being sensitive to different foods is found in Lucretius, 1st century B.C., who was supposed to have coined the expression, "One man's meat is another man's poison." Galen, who lived from 136 to 200 A.D. recognized the individual's sensitivity to goat's milk. In the Babylonian Talmud, there is a reference to a probable hypersensitivity to egg.

The doctors of the Middle Ages recognized sneezing as the result of various pollens of flowers and also asthma as the result of exposure to various flowers. We note this in the writings of Botallus in 1565, Van Helmont, 1600 and Benningerus in 1673. A transfusion of lamb's blood into a human by Denis in 1667 resulted in a severe reaction.

Hay fever was recognized as such by Elliotson in 1839, and as resulting from specific pollens by Blackley in 1873. It wasn't until this century that things became generally recognized and specific agents identified. That is about as far as we are today. The field is still wide open for study and investigation; and the following list of books in the Faculty library give only a portion of the story of allergy.

- Helmont, J. B. v. *Ortus medicinae*. Ed. quarta. Lugduni, J. A. Hugetan et G. Barbier, 1667.
- Withers, T. A treatise on the asthma. London, G. G. J. and J. Robinson, 1786.
- Magendie, F. *Lectures on the blood*. Philadelphia, Haswell, Barrington and Haswell, 1839.
- Salter, H. H. *On asthma*. Philadelphia, Blanchard and Lea, 1864.
- Liveing, E. *On megrim, sick-headache, and some allied disorders*. London, J. and A. Churchill, 1873.

- Wyman, M. *Autumnal catarrh (hay fever)*. New York, Hurd and Houghton, 1876.
- Pirquet, C. v., and Schick, B. *Die Serumkrankheit*. Leipzig, F. Deuticke, 1905.
- Rosenau, M. J., and Anderson, J. F. *A study of the cause of sudden death following the injection of horse serum*. Washington, Government printing office, 1906.
- Pirquet, C. v. *Klinische Studien über Vakzination und vakzinale Allergie*. Leipzig, F. Deuticke, 1907.
- Richet, C. R. *Anaphylaxis*. Liverpool, University press, 1913.
- Duke, W. W. *Allergy; asthma, hay fever, urticaria and allied manifestations of reaction*. St. Louis, C. V. Mosby, 1925.
- Leeuwen, W. S. v. *Allergic diseases*. Philadelphia, J. B. Lippincott, 1925.
- Balyeat, R. M. *Hay-fever and asthma*. Philadelphia, F. A. Davis, 1926.
- Laroche, G., Richet, C., fils, and Saint-Girons, F. *Alimentary anaphylaxis (gastro-intestinal food allergy)*. Berkeley, University of California press, 1930.
- Rackemann, F. M. *Clinical allergy, particularly asthma and hay fever*. New York, Macmillan, 1931.
- Coca, A. F., Walzer, M., and Thommen, A. A. *Asthma and hay fever in theory and practice*. Springfield, C. C. Thomas, 1931.
- Vaughan, W. T. *Allergy and applied immunology*. St. Louis, C. V. Mosby, 1931.
- Coke, F. *Colds and hay fever*. London, Baillière, Tindall and Cox, 1933.
- Feinberg, S. M. *Allergy in general practice*. Philadelphia, Lea and Febiger, 1934.
- Vaughan, W. T. *The practice of allergy*. St. Louis, C. V. Mosby, 1939.
- Tuft, L. *Clinical allergy*. Philadelphia, W. B. Saunders, 1937.
- Coke, F. *Asthma*. 2d ed. Baltimore, Williams & Wilkins, 1939.
- Rowe, A. H. *Elimination diets and the patient's allergies*. 2d ed. Philadelphia, Lea and Febiger, 1944.
- Taub, S. J. *Essentials of clinical allergy*. Baltimore, Williams & Wilkins, 1945.
- Gay, L. N. *The diagnosis and treatment of bronchial asthma*. Baltimore, Williams & Wilkins, 1946.
- Sterling, A. *Clinical allergy*. New York, International universities press, 1947.
- Abramson, H. A. *Psychodynamics and the allergic patient*. St. Paul, Bruce Pub. Co., 1948.
- Rinkel, H. J., Randolph, T. G., and Zeller, M. *Food allergy*. Springfield, C. C. Thomas, 1951.
- Sheldon, J. M., Lovell, R. G., and Mathews, K. P. *A manual of clinical allergy*. Philadelphia, W. B. Saunders, 1953.

\* Chairman, Library Committee.

In cases where there are several editions of a title only the earliest edition in the library is listed. A number of important contributions in the history of allergy are also available in the library's periodical collection. The library staff will be glad to get these out for anyone who is particularly interested.

## LIBRARY CHATTER

MARY EMILY BERGE\*

"The Doctor Writes," edited by S. O. Waife and published by Grune and Stratton we found perfectly absorbing. This "anthology of the unusual in current medical literature" covers a wide range of topics culled from medical journals in 1953. A psychoanalytic interpretation of the status of the Queen in chess, medical stamps, Sherlock Holmes as a dermatologist, and "an unusual obstetrical case history derived from the pen of W. Shakespeare" are but four of the articles which should be greatly appreciated. Our own Dr. Louis Krause is one of the contributors and we feel sure all Faculty members will enjoy this collection.

Another interesting collection in a more serious vein is "Seventy-five Years of Medical Progress, 1878-1953," edited by Louis H. Bauer and published by Lea & Febiger. Dr. Bauer explains in the foreword how the volume came about. "The unique nature of the book is a result of the First Western Hemisphere Conference of The World Medical Association which was held in Richmond, Virginia in April, 1953. The theme of the Conference was the commemoration of seventy-five years of medical progress. Men of distinguished attainments in each of the nineteen medical specialties . . . as well as a representative of general practice, were invited to contribute papers on the history and the present status of their particular fields in medicine. The book is a compilation of these papers." Two Faculty members are contributors to this volume, Dr. Alfred Blalock and Dr. Nicholson J. Eastman.

A new monograph "which will bring the reader up to date with the latest thought on the application of surgery to the treatment of pulmonary tuberculosis" was recently added to the library. Published by Lea & Febiger in 1954, "The Surgery of Pulmonary Tuberculosis" was written by James H. Forsee,

chief of surgical services at Fitzsimmons Army Hospital, Denver, Colorado.

"Antiseptics, Disinfectants, Fungicides, and Chemical and Physical Sterilization," edited by George F. Reddish and published by Lea & Febiger in 1954 has also been added to the library's collection. Various authorities, experts in antimicrobial research, have contributed articles to this volume which covers "the most important facts relating to antimicrobial agents generally, exclusive of antibiotics and chemotherapeutic drugs."

A number of new editions of old titles are now on the library's shelves and are listed briefly here.

Dieckmann—The toxemias of pregnancy. 2d ed.

Crossen—Diseases of women. 10th ed.

Mazer & Israel—Diagnosis and treatment of menstrual disorders and sterility. 3rd ed.

Nelson—Textbook of pediatrics. 6th ed.

Holt & McIntosh—Holt Pediatrics. 12th ed.

Harrow and Mazur—Textbook of biochemistry. 6th ed.

Wiener—Surgery of the eye. 3rd ed.

Ackerman & Regato—Cancer; diagnosis, treatment, and prognosis. 2d ed.

## SUMMARY OF LIBRARY ACTIVITIES IN 1954

HELEN WHEELER\*

The big event of the year was the installation of open shelves in the Reading Room in April, making accessible to readers the books published in the last ten years. Here they are arranged by subject on labelled shelves, where they may be consulted with ease. This change has been received with enthusiasm by most of the doctors. Certainly more of them have worked in the library recently, instead of taking material home.

In spite of this, 3,709 volumes were taken out, an increase of 86 volumes over the previous year. We counted 2,479 volumes brought out of the stacks for use in the library, but of course could not count the books used from the open shelves in the Reading Room or the recent journals used in the Periodical Room.

The attendance for the year was 3,504, an increase of 386 over 1953. This, as well as the increase in number of books circulated, took place in the second

\* Assistant librarian.

\* Librarian.

half of the year, so we hope this indicates a trend which will continue.

We have continued to answer a great variety of reference questions for members, assembling material on such subjects as the cilio-retinal artery, iontophoresis in ophthalmology, lower nephron nephrosis in relation to transfusion reactions, effect of ammonia fumes on the lungs, lymphatic spread of disease to the lung, hepatic artery ligation for cirrhosis, etc., etc.

We have also compiled bibliographies, verified references, located specific articles, tracked down medical historical information, and of course supplied names, addresses, qualifications, etc. of doctors from our directories.

The psychiatric books of the late Dr. G. Lane Taneyhill were given to us, and 42 of them had already been accessioned and made part of our collection before it was learned that he had wanted them to go to the Baltimore Psychoanalytic Society, and they had to be withdrawn from our library.

The fine historical collection of Dr. Stewart Paton, which has been on loan to this library since 1933, was returned to Dr. R. Townley Paton in December for his son, who is a medical student. It consisted of 128 volumes important in medical history, many of them published in the seventeenth and eighteenth centuries. We were sorry to part with these beautiful books, but are glad to have had them for so long.

Six hundred and eighty-three books and 314 bound volumes of periodicals were added to our collection, and 68 books withdrawn, including 42 of

Dr. Taneyhill's collection. The library now contains 78,349 volumes.

Twelve new periodical subscriptions were entered, so that we now receive 325 journals regularly.

Two thousand two hundred and thirty-four books were recatalogued and reclassified by Mrs. Berge, with the help of Miss Miriam E. Carson who joined the staff for a few months. These books are now much more easily found when needed.

We had an unexpected blessing in December, when Miss Grace E. Hatch of the Library of Congress staff did some volunteer work for us during her vacation. Besides doing some difficult cataloguing, she sorted out the large picture and portrait collection which has accumulated through the years without ever being organized, and now we can locate more readily the pictures we have.

Articles, book lists, and library news have been contributed to the *MARYLAND STATE MEDICAL JOURNAL* each month, and exhibits have been held in the library on the subjects of Dr. Krause's articles in the library section of the *JOURNAL*.

There was also an exhibit at the semiannual meeting in Hagerstown of recent books from the library's collection, available for borrowing.

In line with modern library thinking, the staff is trying not only to care for and add to a fine collection, but to make the contents of the books and periodicals readily available to members. Let us know how we can help you.

The librarian is grateful for the fine spirit of cooperation shown by the staff—Mrs. Henry Berge, Miss Myrtle Hollins, and Mrs. Ella Chatt.

#### BALTIMORE PHYSICIAN WINNER OF 1955 MODERN MEDICINE AWARD

Dr. Lawson Wilkins, Baltimore pediatrician and endocrinologist, has been named one of 10 winners and the 1955 Modern Medicine Award for Distinguished Achievement. Announcement of his selection was made by Dr. Walter C. Alvarez, editor in chief of *Modern Medicine* magazine.

Dr. Wilkins received the award for his application of advances in the fields of endocrinology and metabolism to diseases of childhood and adolescence.

Unique feature of the award is that it represents the opinions of members of the medical profession, who vote for the person of their choice on ballot sheets included in *Modern Medicine* issues in the latter months of the year. The annual awards are made in recognition of significant contributions to medicine and the nation's health.



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# Health Departments

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## BALTIMORE CITY HEALTH DEPARTMENT

### Baltimore's Health Highlights for 1954

A decline of 23 per cent in the tuberculosis death rate, a low and favorable experience in respect to pneumonia and influenza deaths, combined with a noticeable drop in mortality ascribed to the diseases of the cardiovascular system have contributed to a new record low death rate in 1954 for both white and nonwhite segments of the population of Baltimore City.

Never before have the Baltimore records shown as low a city death rate as that for the past year. It was 10.6 per 1,000 population. Never before has the death rate been less than 11.2, the figure for the year 1953. This means that the city's health was excellent during 1954, also that more persons are living into the older age groups than formerly.

Baltimore in 1954 had no diphtheria death, no poliomyelitis death, no typhoid fever death, nor any case of smallpox. There were only three diphtheria cases in the entire year, a record never before achieved.

Additional items in the public health record for 1954 worthy of note are: An extraordinary low occurrence of deaths due to influenza, a decline in the reported incidence of meningococcal infections, evidence of a decrease in motor vehicle deaths and a relatively low poliomyelitis year.

Other important public health events in Baltimore during 1954 include:

1. The adoption of new regulations on March 10

to control the hygiene of housing, with the requirement of bathtubs or showers in each dwelling unit; and the favorable court decision on these regulations by Judge E. Paul Mason on October 22.

2. The opening of the new Eastern Health District building first put in use for clinic services at Caroline and Monument Streets on November 22.

3. Publication on October 25 of the Report of Mayor Thomas D'Alesandro's Commission on Aging and the Problems of the Aged.

4. Completion in May of a home accident prevention survey conducted by all public school children and their families with the assistance of the City Department of Education, the Baltimore Safety Council, and the Baltimore City Health Department.

5. Continuance for a second year of the work of an important research committee to study all anaesthetic deaths in Baltimore, the committee jointly appointed by the Baltimore City Medical Society and the Commissioner of Health.

6. A further reduction in the city's tuberculosis death rate as a result of the home drug treatment program.

7. The approval by the voters of the city on November 2 of a \$1,000,000.00 bond issue to provide a new Western Health District building in the vicinity of the University of Maryland Hospital and Medical School.

*Huntington Williams, M.D.*

*Commissioner of Health*

STATE OF MARYLAND DEPARTMENT OF HEALTH  
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, January 28-February 24, 1955

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS
																			Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County....	55	—	4	—	7	1	11	—	—	—	15	—	—	11	10	2	1	w-1	12
Anne Arundel.....	10	—	5	2	26	—	4	—	—	—	6	—	—	1	2	1	6	—	3
Howard.....	—	—	—	—	—	—	—	—	—	—	14	—	—	1	—	—	—	—	—
Harford.....	10	—	—	1	—	—	2	—	—	—	1	—	—	—	1	—	2	—	3
Carroll.....	2	—	—	1	—	—	—	—	—	—	4	—	—	—	—	—	—	—	5
Frederick.....	25	—	1	4	4	—	46	—	—	—	276	—	—	—	1	—	—	—	1
Washington.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	7	—	—	—	4
Allegany.....	10	—	—	—	—	—	—	—	—	—	33	—	—	—	1	—	—	—	5
Garrett.....	—	—	—	—	—	—	—	—	—	—	12	—	—	—	—	—	—	—	1
Montgomery.....	37	—	5	13	22	—	10	—	1	—	83	—	—	—	8	—	—	—	9
Prince George's.....	18	—	8	2	41	—	7	—	—	—	17	—	—	5	6	—	4	t-1	4
Calvert.....	1	—	—	8	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Charles.....	14	—	—	—	—	—	1	—	—	—	1	—	—	—	—	—	—	—	2
Saint Mary's.....	—	—	—	2	—	—	6	—	—	—	18	—	—	1	—	—	—	—	1
Cecil.....	—	—	—	2	—	—	1	—	—	—	1	—	—	—	—	1	—	—	4
Kent.....	40	—	—	—	—	—	2	—	—	—	2	—	—	1	—	—	1	—	3
Queen Anne's.....	—	—	—	—	—	—	1	—	—	—	—	—	—	—	3	—	—	—	—
Caroline.....	—	—	—	—	—	—	3	—	—	—	1	—	—	4	1	—	2	—	—
Talbot.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	5	—	1
Dorchester.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	3	—	3
Wicomico.....	33	—	—	4	—	—	64	—	—	—	20	—	—	—	1	—	9	—	1
Worcester.....	1	—	—	—	—	—	.1	—	—	—	3	—	—	—	—	—	—	—	—
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—
Total Counties.....	256	0	23	39	100	1	159	0	1	0	507	0	0	24	43	4	34	—	63
Baltimore City.....	35	1	12	1	25	1	71	1	0	0	42	0	0	11	78	4	481	a-2	36
State																			
Jan. 28-Feb. 24-'55...	391	1	35	40	125	2	230	1	1	0	549	0	0	35	121	8	515	—	99
Same period 1954.....	553	4	37	135	1446	5	401	1	0	0	230	0	0	80	195	21	482	—	71
5-year median.....	491	3	30	—	665	9	251	1	—	0	192	1	2	55	188	24	533	—	71
Cumulative totals																			
State																			
Year 1955 to date....	717	1	61	73	192	5	362	2	1	0	921	0	0	79	258	21	1105	—	177
Same period 1954.....	1167	4	53	185	2136	9	772	2	0	0	349	0	0	169	311	39	1121	—	132
5-year median.....	866	8	52	—	1085	15	452	3	—	0	345	3	4	125	347	47	1073	—	132

a = amoebic dysentery.

t = tularemia.

w = Weil's disease.



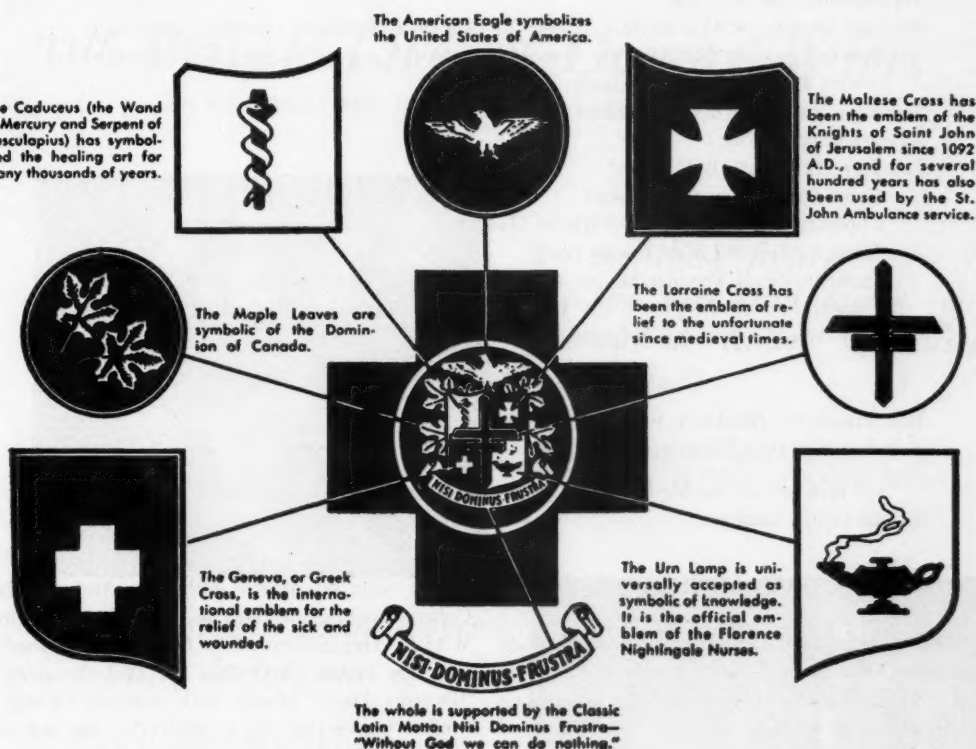
# Blue Cross - Blue Shield



## What's the Meaning of the Blue Cross Emblem?

To use the Blue Cross symbol with the superimposed seal of approval of the American Hospital Association, each Blue Cross Plan must annually meet rigid standards of approval. This sets Blue Cross apart from other plans, and distinguishes us as non-profit organizations devoted solely to the welfare of the community, and sponsored by the hospitals.

Here is what the various parts of the official emblem of the American Hospital Association mean:





# Woman's Auxiliary Medical and Chirurgical Faculty



MRS. JOHN G. BALL, *Auxiliary Editor*

## WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY SIXTH ANNUAL MEETING

*Tentative Program*

THURSDAY, APRIL 21, 1955

*Place:* Sheraton Belvedere Hotel

*Registration:* 9:00-9:30 A.M.

*Business Meeting:* 9:45 A.M. Mrs. Albert E. Goldstein, President, presiding Auxiliary

Special Reports: Members are urged to attend this session, so they will be conversant with activities of the Auxiliary.

*Necrology:* Just prior to adjournment

*Adjournment:* 12 noon

*Luncheon:* 12:30 P.M. Ball Room\*

Guest Speaker to be announced

Coronation of The Student Nurse of Maryland

Music by Dr. and Mrs. Joseph Blum

Presentation of Presidential pin to Mrs. Gerald LeVan by Mrs. Albert E. Goldstein

Presentation of the pin to the Immediate Past President, Mrs. Albert E. Goldstein, by Mrs. Thomas A. Christensen

FRIDAY, APRIL 22, 1955

Past Presidents' Breakfast, 9:00 A.M.

*Postconvention Board Meeting:* 10:30 A.M.

\* All members of the Medical and Chirurgical Faculty and their wives are most cordially invited to this luncheon.

## DOCTOR'S DAY, MARCH 30, 1955

Many interesting events are being planned throughout the state in observance of "Doctors Day." March 30th will be set aside by Governor's Proclamation as a day to honor the doctors of Maryland. Red carnations will appear in many doctors' coat lapels as that flower honors the doctor on this day. "Doctors Day" provides Auxiliaries with an excellent opportunity to remind the public of the benefits of modern medicine, the service of the physician to his community and also to reveal the doctor as a human being.

Last year on March 30th, Dr. Archie Robert Cohen broadcast a talk on "Doctors Day" over WARK, Hagerstown. This talk was published in the July, 1954 "JOURNAL." It told the story of "Doctors Day." March 30th was not chosen at random but on that day in 1842, ether was first used as an anesthetic agent on a human being. This was a great step forward for medicine and particularly surgery, for before then, surgery had been a heroic procedure for both patient and doctor. Dr. Crawford Long of Georgia was the surgeon who successfully operated on a patient under anesthesia for the first time.



At right are a few of the chorines from the cast: MRS. HAROLD ROSEN—Pianist, *left to right*: MMES. HAROLD VYNER, HARRY BECK, WALTER KOHN, ISADORE SBOROFKY, E. ELLSWORTH COOK, IRVING J. TAYLOR, HERBERT COPELAND, JOHN HIRSCHFELD, JOHN ROSIN, ARTHUR MANDY, THEODORE KARDASH, and MARION FRIEDMAN.

THE WOMAN'S AUXILIARY OF THE  
BALTIMORE CITY MEDICAL SOCIETY

*will present at the*

‘‘MED-CHI’’ BALL

ON APRIL 22, 1955



## THE *Private Lives* OF Doctors' Wives

AN ORIGINAL MUSICAL BY MRS. IRVING J. TAYLOR



*To see these figures come to life—be sure and make your reservation early! A sellout is expected!*

Taking time out are, *left to right*, MMES. E. E. COOK, I. J. TAYLOR, H. COPELAND and W. KOHN.

*The cast will include over  
fifty doctors and wives!*

Ready to resume rehearsing are *l. to r.* MMES. M. FRIEDMAN, E. E. COOK, T. KARDASH, H. VYNER, I. J. TAYLOR, H. COPELAND, T. MANDY, W. KOHN and J. ROSIN.

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for Reservations call or write:

MRS. E. ELLSWORTH COOK, Jr.  
11 McKIM AVE.  
BALTO., MD. — VA-5-9189



In speaking of the Governor's Proclamation Dr. Cohen says, "The proclamation honors the entire medical profession, not only your family physician, whom you call in time of illness, but, in addition, the surgeon in the immaculate operating room who has been called into consultation by your family physician; the pathologist in his laboratory of the hospital, where the necessary tests of the blood and other materials of the body are performed; the research physician who devotes his life to the study of causes of disease; the public health physician who has made a long study of the relationship of various diseases and infections to the health of the general public and the methods to be used in the prevention of these illnesses; the radiologist who through the use of X-ray is able to explore and diagnose conditions in the deeper portions of the human body; the atomic physician with his Geiger counter, and study of the effect of radiation on experimental animals and unfortunately on some humans; the bacteriologist and the virologist who work with research physicians in the study of cause and effect."

### BITS FROM THE JOURNALS AND NEWS-LETTERS OF OTHER AUXILIARIES

*Arizona* has this timely reminder for all of us—

Do you.....?

Did you.....?

DUES YOU!!!!

\$\$\$\$\$ for county, state and national

*New Mexico:* Legislation of Interest to Medicine  
Between you and your Congressman:

1. Do you think Social Security for physicians should be compulsory or voluntary?
2. Your stand concerning *free* hospitalization to veterans with *non-service connected disabilities*?
3. Should the Federal Government participate in a re-insurance program?
4. Do you feel that dependents of military personnel should have a further extension of medical care?

*Utah:* Be informed

GRIBE! GRIBE! GRIBE! At Whom? About What? Why? What are you doing to correct the

matter? These questions do not apply to legislation alone but to every phase of living.

The gripes concerning government have two causes—inactivity and ignorance. The person who does not avail himself of his right to vote has no cause to gripe. The person who fails to know the facts of an issue at stake is sacrificing his privilege to gripe also.

It is impossible to correct a situation without effort on the part of someone, and that someone may be you. Do not shirk your responsibility. Many laws have been passed and many have been barred by a single vote. Know why such a law is considered necessary and whether the law will accomplish the necessary results. Do not be swayed by a smooth speaker. Investigate, study, and above all, make up your own mind. Try this just once and you will note a definite change in attitude and also greatly increased interest.

There is at this time a great need for study, decisions, and then activity in our State in regard to the Medical Examiner's Bill. Please give this issue all your support. Educate yourself and then help to educate others.

Mrs. Noall Tanner

*Tennessee:* Doctor's Wife Has Her Own Ten Commandments

1. She must not know the meaning of the word "jealous."
2. She must never gossip.
3. She must run a cafeteria, serving meals at all hours for her husband.
4. She must be—like Caesar's wife—above reproach.
5. She must have self-reliance and self-control.
6. She must be able to think quickly and sanely in emergencies.
7. She must be a diplomat, see all, hear all, say a lot, yet say nothing.
8. She must learn to bear socially and without complaint, disappointments in her personal plans.
9. She must be a good mother and father, because doctors are often too busy to discipline their own children.
10. She must be a good "doctor" because doctors never take time to doctor themselves.

Author Unknown

**West Virginia: Garden Therapy For The Mentally Ill**

What is Garden Therapy? It is bringing the gospel of Hope to the blind, the mentally ill, the handicapped—junior or adult—through the fine art of gardening. ... If you take flowers to the sick, you perform a kindness and give pleasure, but if you teach that sick person to grow a beautiful flower or vegetable, tree or shrub himself, then you are helping to heal a sick body and mind, and that is Garden Therapy.

One interesting phase of Garden Therapy is the making of Button Gardens. They are simply tiny bouquets which are scarcely an inch and a half high mounted on two or three inch buttons which serve as bowls for the diminutive arrangements. What fun, you as Auxiliary members could have, by, together, concocting these bouquets out of calyxes and other parts of weeds and flowers. Don't take nature as you find it! Pull it apart and dissect weeds and blossoms into miniature. Some flowers and seed pods can be dried and colored.

Button Gardens can be a real challenge and an opportunity for us in our Mental Health Program, if the project is kept in accordance with the prescribed medical treatment of the patients. There is a great need for enthusiastic leaders to plan and supervise this fine program in all sections of our land. The challenge is ours to accept!

**REMEMBER!**

Annual Meeting of the Woman's Auxiliary to the Medical and Chirurgical Faculty will be held Thursday, April 21st, at Hotel Belvedere.

Med-Chi Ball will be held Friday, April 22nd, at the Emerson Hotel, 9:00 p.m.—1:00 a.m.  
Plan now to attend!

**MANAGING PUBLISHER NAMED FOR TODAY'S HEALTH MAGAZINE**

CHICAGO—William W. Hetherington has been named managing publisher of Today's Health magazine, the official consumer publication of the American Medical Association.

Dr. George F. Lull, secretary-general manager of the AMA, announced the creation of the position and Hetherington's appointment. He said "it is contemplated that the magazine, with more than 350,000 circulation, will be expanded and developed to further attain the basic objective of publishing a modern, authentic, effective and popular publication for the general public. Mr. Hetherington's duties will include the coordination of the editorial, circulation and advertising sections of the publication."

Doctor Lull also announced a six-man editorial board for Today's Health: Drs. Walter E. Vest, Huntington, W. Va.; Julian P. Price, Florence, S. C.; Austin Smith, editor of the Journal of the AMA; George F. Lull; Mr. Leo Brown, director of the AMA's Department of Public Relations, and Dr. W. W. Bauer, chief editor of Today's Health and chairman of the editorial board.

Hetherington, of Evanston, Ill., has been a staff member of Today's Health since 1948, with primary responsibility in advertising and sales activities.

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**UNIVERSITY OF MARYLAND MEDICAL SCHOOL,  
DEPARTMENT OF PEDIATRICS**

**FOURTH ANNUAL PEDIATRIC SEMINAR**

Gordon Wilson Hall, University Hospital, Baltimore

*Sunday, March 27, 1955, 10:00 a.m.*

Some Common Endocrine Disorders of Childhood. Robert B. Greenblatt, M.D.  
Head Injuries in Children. Eugene B. Spitz, M.D.  
Psychosomatic Aspects of Pediatric Allergic Conditions. Bret Ratner, M.D.  
Some Problems of the Newborn. Stewart H. Clifford, M.D.

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## Coming Meetings

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### OPHTHALMOLOGICAL SECTION\*

FRED M. REESE, M.D., *Chairman*

HERMAN K. GOLDBERG, M.D., *Secretary*

#### JOINT MEETING WITH OPHTHALMOLOGICAL SECTION OF THE DISTRICT OF COLUMBIA MEDICAL SOCIETY

*Tuesday, April 12, 1955*

Kennedy-Warren Hotel, Washington, D. C.

Cocktails 6:00 p.m.

Dinner 7:00 p.m.

Scientific Session 8:00 p.m.

Muscles. Frank D. Costenbader, M.D.

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### POSTGRADUATE INSTITUTE DOCTORS HOSPITAL

Spring Session (1955)

#### PEDIATRICS IN GENERAL PRACTICE

PANEL DISCUSSIONS—Tuesday Nights (9:15 p.m.)

April 5—Problems of Early Infancy (non-feeding)\*

April 19—Neurologic Diseases (Palsy, Polio, Infections, Brain Tumors)

May 3—Pediatric Emergencies

May 17—Psychiatric Disturbances

ROUND TABLE DISCUSSIONS—Luncheon (1 p.m.)

April 1, 12, 26, 29—Normal Newborn, Immunization, Febrile Convulsions, Asthma and Allergy.

May 6, 20—Diarrhoeas, Miscellaneous Problems.

LECTURES—Wednesdays (3:30 p.m.)

April 13—Ear, Nose, and Throat Panel.

April 20—Juvenile Diabetes; Nephrotic Syndrome.

May 11—Tumor and Cancer Panel.

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\* In view of the recent courses on Infant Feeding and Congenital Heart Disease given by the Baltimore City Medical Society, those subjects are excluded from this course.

For further information, write Dr. Wm. Schuman, Doctors Hospital, 2724 N. Charles St.



## PRESIDENT PROPOSES BROAD HEALTH PROGRAM

The AMA Washington Letter, No. 84-2

In his State of the Union Message January 6 President Eisenhower told Congress that his administration would make eight broad proposals in the health fields. They are:

1. A federal health reinsurance service. The message did not say how closely this would resemble the reinsurance bill defeated last year.
2. Measures to improve medical care for federal-state public assistance recipients. (Possibly through establishment of a U.S.-state matching fund to be used exclusively for payment of these medical costs.)
3. New measures "to facilitate the construction of needed health facilities and help reduce shortages of trained health personnel." This could mean any of a number of plans for aid to medical schools, and federal guarantee of mortgages on hospitals and health centers.
4. "Vigorous steps" to combat mental illness through a federal program.
5. Improved service for crippled children and for maternal and child health.
6. Better consumer protection under the existing pure food and drug laws.
7. Strengthened programs "to combat the increasingly serious pollution of our rivers and streams and the growing problem of air pollution."
8. An expanded program for medical care of military dependents. Details will be given January 13 in a special message on problems of military personnel.

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## EISENHOWER URGES DEPENDENT MEDICAL CARE AND PAY INCREASES

The AMA Washington Letter, No. 84-3

In one of two special messages to Congress January 13, President Eisenhower urged legislation to increase medical care to military dependents as one of the steps to halt "the high personnel turnover rate" in the armed forces. He said field studies made by the services showed that a very large proportion of the men in uniform "expressed dissatisfaction with traditional service benefits such as PX facilities, dependents' medical care, family housing, death benefits for survivors, and related items."

The President declared that wherever administrative action can improve conditions, action is being taken by the services. However, legislation is needed for changes in most benefits, and the President added that Congress should remove "existing inequities" and provide for "better medical care for military families."

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## U. S. EMPLOYEE UNIONS WANT PRESENT HEALTH PLANS PROTECTED

The AMA Washington Letter, No. 102

U. S. workers, speaking through a committee representing the federal employee unions, have informed the Civil Service Commission that they want to preserve their present voluntary health plans under any health insurance program to be worked out for them. A task force of the Civil Service Commission, under Warren Irons, is attempting to draft legislation for contributory, payroll deduction health insurance for all federal civilian employees. Large groups of U. S. employees at present are enrolled in several of their own health insurance plans, supported entirely by the employees.

The government workers also are insisting that a uniform, nationwide indemnity plan be made available, but that groups of employees have the option of taking this coverage or contracting for some other.

# *Annual All-Faculty Dance!*

STATE-WIDE BALL TO BE PART OF ANNUAL MEETING

APRIL 21, 22, 23, 1955

Make reservations early for the Med-Chi Faculty Ball to be held on Friday, April 22, 1955 from 9:30 until 1:30 a.m., at the Emerson Hotel, sponsored by the Woman's Auxiliary to the Baltimore City Medical Society.

*Be a patron, be present, be prompt!*

An original show with songs and dances entitled "Private Lives of Doctors' Wives" will be presented at 10 p.m. SHARP. Tickets may be purchased at the door. An early return of the forms below will be appreciated.

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Please reserve for me a table for \_\_\_\_\_ persons.

*Mail to or call:*

Mrs. E. Ellsworth Cook, Jr.  
11 McKim Avenue  
Baltimore 12, Maryland  
VA 5-9189

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Enclosed please find my check for the patron list. Three dollars minimum patron fee.

Make checks payable to the Woman's Auxiliary to the Baltimore City Medical Society.

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

*Mail to:*

Mrs. John B. DeHoff  
233 Gaywood Road  
Baltimore 12, Maryland